DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

EMERGENCY SERVICES DEPARTMENT

TRAUMA NURSING ASSESSMENT SHEET

MRN: 4131790
LAMBDA,F
UN / U
HAR: 602194488
CSN: 310183284

DOB:
Adm:
Age:
Dep:
Pln:

Name: _____ MR#: _____ SS#: _____ AGE: _____ SEX: _____ RACE: _____

ARRIVAL DATE: 3/23/07 TIME: 1930 TIME OF INJURY: 1900 ACTUAL / ESTIMATED

☒ INTENTIONAL INJURY ☐ UNINTENTIONAL INJURY

ACTIVATION OF TRAUMA TEAM ☒ LEVEL I ☐ LEVEL II ☐ LEVEL III

MECHANISM OF INJURY

MOTOR VEHICLE TRAUMA

☐ MVC ☐ MPC ☐ MCC ☐ ATV ☐ BICYCLE ☐ OTHER: _____ ☐ DRIVER PASSENGER: ☐ FRONT ☐ REAR EJECTED _____ FT.

☐ TYPE OF VEHICLE: _____ ☐ FATALITIES AT SCENE X _____ SPEED OF CRASH: _____ MPH.

TYPE OF COLLISION: ☐ HEAD-ON ☐ SIDE IMPACT (T-BONE) ☐ REAR-ENDED ☐ ROLL-OVER ☐ OTHER: _____

SAFETY DEVICES: ☐ SEATBELT 2 PT. / 3 PT. ☐ UNRESTRAINED ☐ CHILD SAFETY SEAT ☐ AIRBAG ☐ HELMET ☐ OTHER: _____

FALL / JUMP TRAUMA

APPROXIMATE HEIGHT: _____ FT. LANDED ON SURFACE TYPE: _____

COMMENTS: _____ ☐ POLICE NOTIFIED

ASSAULT ☐ ALLEGED CRIMINAL ASSAULT

WEAPON USED: _____ ☐ AGGRAVATED ASSAULT ☐ POLICE NOTIFIED

COMMENTS: _____

PENETRATING

☒ GSW ☐ SGW ☐ SW ☐ IMPALEMENT ☐ OTHER: _____

DISTANCE FROM ASSAILANT: unknown # OF WOUNDS: _____

WEAPON / DESCRIPTION: Multiple ☒ POLICE NOTIFIED

THERMAL

☐ FLAME ☐ CHEMICAL ☐ ELECTRICAL ☐ FROSTBITE ☐ POTENTIAL INHALATION

DESCRIPTION: _____

☐ ENCLOSED SPACE LENGTH OF EXPOSURE: _____

OTHER

DESCRIBE: _____

TRANSPORT

PREHOSPITAL TRANSPORT ☐ PRIVATE VEHICLE ☐ POLICE ☒ AMBULANCE CO.: DFD AIR / GROUND UNIT# _____

☐ O_2 _____ ☐ ORAL AIRWAY ☐ ETT# _____ ☐ EOA ☐ BVM ☐ C-COLLAR ☒ BACKBOARD ☐ OTHER _____ ☐ SPLINT _____

☐ CPR-MANUAL/THUMPER ☐ PRESSURE DRESSING ☐ MEDS ☒ IVs INITIATED TOTAL INTAKE: _____ ESTIMATED BLOOD LOSS: _____ cc

REFERRING FACILITY: _____ Time Admitted: _____ Time Transferred: _____

PRIMARY SURVEY

AIRWAY ☒ PATENT ☐ PARTIALLY OBSTRUCTED ☐ OBSTRUCTED

☐ SECRETIONS ☐ FOREIGN BODY ☐ OTHER: _____

☐ SPINE PRECAUTIONS MAINTAINED BY: _____

INTERVENTIONS ☐ ETT# _____ - ORAL / NASAL ☐ NASAL TRUMPET

☐ ORAL AIRWAY ☐ CRICOTHYROIDOTOMY ☐ TRACHEOSTOMY

TIME: _____ BY: _____, MD BREATH SOUNDS √'d ☐ YES ☐ NO

COMMENTS: _____

BREATHING ☒ SPONTANEOUS ☐ LABORED ☐ AGONAL

TRACHEA: ☒ MIDLINE ☐ DEVIATED - R L

CHEST WALL: ☒ WNL ☐ ABN: _____

BREATH SOUNDS: RIGHT ☒ WNL ☐ DIMINISHED ☐ ABSENT

LEFT ☒ WNL ☐ DIMINISHED ☐ ABSENT

☐ SUCKING CHEST WOUND ☐ FLAIL - R L

TIME

_____ ☐ BREATHING ASSISTED WITH BAG-VALVE DEVICE

_____ ☐ RIGHT THOROCOSTOMY TUBE PLACED INITIAL OUTPUT: _____

_____ ☐ LEFT THOROCOSTOMY TUBE PLACED INITIAL OUTPUT: _____

_____ ☐ NEEDLE THOROCOSTOMY — R L ☐ AIR EXPRESSED

_____ ☐ OCCLUSIVE DRESSING TO: _____

_____ ☐ O_2 ADMINISTERED BY: _____ AT _____ L

CIRCULATION COLOR: ☐ WNL ☒ PALE ☐ CYANOTIC ☐ FLUSHED

SKIN: ☐ WNL ☒ COOL ☐ HOT ☐ CLAMMY ☐ DIAPHORETIC

PULSES: ☒ PRESENT ☐ ABSENT ☐ DIMINISHED ☐ THREADY

HEMORRHAGE: ☐ NONE ☐ GROSS: _____ ☐ ESTIMATED BLOOD LOSS _____ cc

TIME

_____ ☐ AUTO TRANSFUSION UTILIZED _____ cc

_____ ☐ PRESSURE DRESSING TO: _____

_____ ☐ IVs ESTABLISHED (SEE INTAKE RECORD)

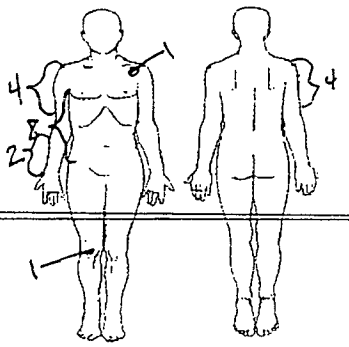
_____ ☐ PERICARDIOCENTESIS ☐ THOROCOTOMY ☐ CPR INITIATED *(see CPR record)*

_____ ☐ LEVEL 1 FLUID WARMER UTILIZED _____

DISABILITY NEURO: ☐ ALERT ☒ RESPONDS TO VERBAL ☐ RESPONDS TO PAIN ONLY ☐ UNRESPONSIVE ☐ + LOSS OF CONSCIOUSNESS X - _____ MN

PUPILS RIGHT: SIZE 4-2 ☐ REACTIVE ☐ SLUGGISH ☐ UNREACTIVE LEFT: SIZE 4-2 ☒ REACTIVE ☐ SLUGGISH ☐ UNREACTIVE

• = GSW
L / = LACERATION
AMP = AMPUTATION
FX = DEFORMITY
■ = BURN
A = ABRASIONS
C = CONTUSION
H = HEMATOMA



2 3 4 5 6 7 8 9

PUPIL SIZE

006

PS 575 (Front) Revised 12/04/01 (RTB)

SECONDARY SURVEY

HEAD AND FACE (L)cheek lac 1cm

Head: ☐ NORM ☒ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION ☐ + AMNESIA TO EVENT
Describe: (L)eyebrow circular wound, (R)parietal hematoma

Eyes: ☒ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION ☐ RACOON SIGN/BATTLE SIGN
GAZE: ☒ NORMAL ☐ DISCONJUGATE ☐ DIPLOPIA
Describe:

Ears: ☒ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION
☐ OTORRHEA ☒ RTM clear ☒ LTM clear Describe:

Nose: ☒ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION
☐ RHINORRHEA Describe:

Mouth/ Throat: ☐ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☒ LACERATION ☐ ABRASION
☐ CONTUSION ☐ TEETH MALOCCLUSION ☐ TEETH MISSING
Midface: ☒ Stable ☐ Unstable
Describe: 1cm wound (R)side mouth

NECK / BACK ☐ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION ☐ PAIN
☐ JVD Carotid: ____ + R ____ + L C-COLLAR IN PLACE ☐ Y ☒ N ☐ N/A ☐ Crepitus Bruit: ____ R ____ L
Describe: large amts blood over neck

CHEST ☐ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION ☐ RIB TENDERNESS
☐ STERNAL TENDERNESS ☐ SEAT BELT MARKS
Breath Sounds Present: ☐ RLL ☐ RUL ☐ LLL ☐ LUL ☐ Subcutaneous air Location: ☐ Crepitus Location:
Describe: (R)lat chest GSW (R)lat costal margin

CARDIAC ☐ NSR ☒ OTHER RHYTHM ☐ DISTANT HEART SOUNDS ☐ ABNORMAL HEART SOUNDS
Describe: ST

ABDOMEN ☐ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION
☐ TENDER: ☐ LUQ ☐ RUQ ☐ LLQ ☐ RLQ ☐ RIGID ☐ SEATBELT MARKS ☐ DISTENTION
Bowel Sounds: ☐ Present ☐ Absent ☐ Scars:
Describe: (R)flank GSW, abd soft

LVIS/GU ☐ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION ☐ TENDERNESS
☐ BLOOD AT MEATUS ☒ PELVIS - STABLE / UNSTABLE ☒ RECTAL EXAM DONE ☒ TONE deferred ☐ CATHETER ____ ☒ PROSTATE normal
Genitalia: ☒ Norm ☐ Hematoma/Swelling ☐ Deformity ☐ Laceration ☐ Abrasion ☐ Contusion good tone
Describe:
Uterus: LNMP ____ ☐ Pregnant ____ wks. ☐ FHT____ G____ P____ Comments:

EXTREMITIES ☐ NORM ☐ HEMATOMA/SWELLING ☐ DEFORMITY ☐ LACERATION ☐ ABRASION ☐ CONTUSION DOMINENT HAND: ☐ R ☐ L
Describe: (R)knee GSW, RUE muscle GSW -4, (L)expanding hematoma (R)axilla GSW-2, 8 GSW between (R)axilla & chest/back 1 GSW (L)shoulder

Motor Funtion: ☐ NORMAL Deficit: ☐ RUE ☐ LUE ☐ RLE ☐ LLE (L)bicep GSW
Sensory Function: ☐ NORMAL Deficit: ☐ RUE ☐ LUE ☐ RLE ☐ LLE

Pulses:	Radial	Carotid	Femoral	Popliteal	Posterior Tibial	Dorsalis Pedis
R +	2	3	2			2 (UTA)
L +	2	3	2			2

TIME BACKBOARD REMOVED 1934 ☐ NA ☒ Hypothermia Precautions Initiated warm blankets
LOG ROLL: C Spine precautions
WT: 105 Kg ☐ Obese ☐ Morbidly Obese
ALLERGIES ☐ NKDA
PAST MEDICAL HISTORY:
PAST SURGICAL HISTORY: unknown
IMMUNOCOMPROMISED: ☐ Therapy ☐ Asplenic ☐ IDP
VICTIM OF FAMILY VIOLENCE ☐ Yes ☐ No
TIME OF LAST MEAL

CURRENT MEDICATIONS: unknown
☐ SMOKER ☐ IVDA
☐ ETOH/DRUGS
PRIVATE PHYSICIAN: ☐ Y ☐ N
NAME:

TETANUS TOXOID ☐ Current ☐ .5 cc IM Site
☐ DT Lot #: Time:
Company: Exp. Date:
by:

GLASCOW COMA SCORE

EYE OPENING	SPONTANEOUSLY TO SPEECH TO PAIN NONE		4 (06) 3 2 1
VERBAL	ORIENTED CONFUSED INAPPROPRIATE INCOMPREHENSIBLE NONE	COOS & BABBLES IRRITABLE CRY CRIES TO PAIN MOANS TO PAIN NONE	5 4 3 2 1
MOTOR	OBEYS COMMANDS LOCALIZES WITHDRAWS FLEXION EXTENSION NONE	SPONT MOVEMENTS WITHDRAWS TO TOUCH WITHDRAWS TO PAIN FLEXION EXTENSION NONE	6 5 4 3 2 1
			12

A. RESP		B. SYSTOLIC BP		C. CONVERT GCS		REVISED TRAUMA SCORE
10 - 24	4	> 90	4	13 - 15	4	A + B + C = 11
25 - 35	3	70 - 89	3	9 - 12	3	
> 35	2	50 - 69	2	6 - 8	2	
< 10	1	< 50	1	4 - 5	1	
0	0	0	0			

INITIALS:____ SIGNATURE:____ ID#:____
INITIALS:____ SIGNATURE:____ ID#:____

MRN: 4131790
LAMBDA,F
UN / U
HAR: 602194488
CSN: 310183284

DOB:
Adm:
Age:
Dep:

VITAL SIGNS										INTAKE RECORD							
TIME	GCS / RTS	R UE BP	P	R / VR	P / PS	T/V	O2%	T	O2% SAT	TIME	I.V. BAG	SITE	GA	Soln.	LTC	AMOUNT GIVEN	TOTAL VOLUME
130	17 / 11	92/P	130	12			100	UTA	100	PTA	1	(L) FA	18	NS	900	100	100
1940	12 / 11	LUE 86/P	110	24			100		100								

TOTALS						
PRBC						
FFP						
PLTS						

PUPILS 1 HOUR AFTER ADMISSION:
PUPILS RIGHT: SIZE ________ ☐ REACTIVE ☐ SLUGGISH ☐ UNREACTIVE **LEFT:** SIZE ________ ☐ REACTIVE ☐ SLUGGISH ☐ UNREACTIVE

TIME	PLAN OF CARE / NOTES
1930	Pt. arrives via EMS & police p̄ multiple GSWs to extremities/
	chest/back. 1° & 2° assessments in progress. (JB) (1937) CXR @ BS (JB)
1939	KUB done (JB) (1940) ABIs in progress (JB) (1946) Pt. to CR c̄ multiple physicians
	& Trxc on tele (JB) (1948) Belongings given to police officer Tena #8444

INITIALS: JB SIGNATURE: [signature] RN ID#: 24241
INITIALS: ________ SIGNATURE: ________ ID#: ________
INITIALS: ________ SIGNATURE: ________ ID#: ________
INITIALS: ________ SIGNATURE: ________ ID#: ________

MRN: 4131790 DOB:
LAMBDA,F Adm:
UN / U Age:
HAR: 602194488 Dep:
CSN: 310183284 Pln:

PROCEDURES

TIME	PROCEDURE	RESULTS	TIME	PROCEDURE	RESULTS	TIME	PROCEDURE	RESULTS
	C-SPINE			EKG - 12 LEAD			CENTRAL LINE	
	CLEARED			SPLINT/TRACTION			CHEST TUBE R CHEST TUBE L	
	CHEST		1945	FOLEY			ETT	
	CLEARED			URINE DIP				
				URINE PREGNANCY			VENTRIC	
	PELVIS		1947	LABS	sent		AGRAM	
	ADDITIONAL X-RAYS		1936 1942	INITAL Hgb	15.3 14.8		IVP/CYSTOGRAM	
				REPEAT Hgb			D-STICK	
	MRI			NGT/OGT			OTHER	
	CT			DPL			ABD SONO	deferred by Dr. Shah

CONSULT SERVICES

CONSULTANTS: SERVICE	NAME	TIME CALLED	TIME ARRIVED	SERVICE	NAME	TIME CALLED	TIME ARRIVE
TRAUMA FACULTY	Shah	1922	1930	EMERGENCY MED	Treichler/Fowler	1922	1930
TRAUMA HO 5	Herschberger		OA	THORACIC			
TRAUMA HO 3	Lipschitz			PLASTICS			
TRAUMA HO 2	Wallace/Cumbie			ENT / OMFS			
TRAUMA HO 1	Zhan/Lee			BURN			
TR. NURSE CLINICIAN	Guest/Lucio			UROLOGY			
TR. NURSE CLINICIAN	Gradel/Peter			CHAPLAIN			
ESDRN	Rodriguez			SOCIAL SERVICES			
ORTHOPEDICS				(Circle) CPS APS POLICE VIP			
NEUROSURGERY				OB/GYN			

ASSESSMENT SCORE			Pain Score Before	Pain Score After
Able to move 4 extremities Able to move 2 extremities Able to move 0 extremities	= 2 = 1 = 0	ACTIVITY		
Able to deep breathe and cough freely Dyspnea or limited breathing Apnea	= 2 = 1 = 0	RESPIRATION		
BP: 20% of baseline level BP: 20-50% of baseline level BP: 50% of baseline level	= 2 = 1 = 0	CIRCULATION		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		
Post Procedure score less than 8 at 1 hour requires further assessment and monitoring.		TOTALS		

OUTPUT RECORD					
TIME	URINE	CHEST TUBES RT.	CHEST TUBES LT.	NG	OTHER

Valuables: _____

Envelope #: _____

Huc: _____

MEDICATIONS: *PAIN SCALE*

0 No Pain 1 2 Mild Pain 3 4 Moderate Pain 5 6 Severe Pain 7 8 Very Severe 9 10 Worst Possible

TIME	MED	DOSE	ROUTE	C/S Y/N	PAIN SCALE Before	PAIN SCALE After	INITIALS	TIME	MED	DOSE	ROUTE	C/S Y/N	PAIN SCALE Before	PAIN SCALE After	INITIALS

INITIALS: NS SIGNATURE: _____ ID#: 24241

INITIALS: _____ SIGNATURE: _____ ID#: _____

NITIALS: _____ SIGNATURE: _____ ID#: _____

PS 575 (Back) Revised 12/04/01 RTB

MRN: 4131790
LAMBDA,F
UN / U
HAR: 602194488

DOB:
Adm:
Age:
Dep:

Parkland Health & Hospital System

5201 Harry Hines Blvd.
Dallas, Tx 75235

Emergency Services Dept.
214-590-8000
Assessment Sheet

MR # 000004131790 Sex: Male DOB: 01/01/1984
Name: **Lambda, F**
Phone:
Address: **1250 MOCKINGBIRD #500, DALLAS, TX 75247**
Room #: **Trauma 28** Account # **000310183284** Age: **23**

Complaint: **Mult GSW**
Arrival Date/Time: **19:29 03/23/2007**
Arrived by: **Ambulance / EMS**
Mobility: **Stretcher**
EM Faculty: ***Treichler, 40997,MD, Brent**
Accompanied By:

Acuity: **1 - Resuscitation**
Insurance:
Amb/Helicopter:
Referring Facility:
Resident: **Bruggman, MD 52709, Amanda**

Complaint Code:
Treatment PTA: *** None**

Triage Nurse: **Guerrero, RN 24775, Odette**

Past Medical Hx:
Tetanus History: **NA**
Social History:
Weights:
LMP Date: **NA**

Medications

Medication	Dosage	Freq	Prescribing Phys	Started
***See downtime chart**				

Allergy

Allergy	Allergic Reaction
****None**	

Vital Signs

Inits	Time	Temp	Blood Pressure	Pulse	Resp
KB	20:04		/ Automatic,,		

Pain

Time	Scale
20:04	See C

Pulse Ox.

Time	%

Pupils

Time	L(mm)	R(mm)

Glasgow Coma

Time	Score

Disposition Information
Primary Diagnosis: **Gsw arm, upper, multiple**
Secondary Diagnosis:
Disposition: **Admit As Inpatient**
Report Called By: **James, 4366,, Delores, V**
Tr Nurses
Prescriptions:
Discharge Instructions:
Disability Statement:
Follow-up Care:
Discharge Time: **21:17 03/23/2007**

Family Notificati[redacted]
Report Given To: **Operating, Room - Pt went to OR @ 1946--Transporter--**

Appt Date/Time:

Initials	Name	Initials	Name

PARKLAND HEALTH & HOSPITAL SYSTEM
5201 Harry Hines Blvd., Dallas, TX 75235

Department of Pathology
Laboratory Walk-In Requisition

Desired Collect Date	Desired Collect Time	Actual Collect Date	Actual Collect Time
		3/23/07	2015

Ordering Practitioner: 2615
Print Name: T. Kay Smith
Signature: T. Kay Smith
ID# [illegible] Pager/phone 7615

MRN: 4131790
LAMBDA,F
UN / U
HAR: 602194488
CSN: 310183284
DOB:
Adm:
Age:
Dep:
Pln:

Write Reason number(s) next to Tests Requested

INPATIENTS - Reason(s) for Test (e.g. chief complaints, signs, symptoms, etc.)
1. Bleeding
2.
3.

Write Reason number(s) next to Tests Requested

OUTPATIENTS- Reason(s) for Test **ICD-9 Code(s)**
1.
2.
3.

Lab Order Form has both the Practitioner's signature and the diagnosis. Yes *(Both are required before tests are ordered.)*

ALL OF THE ABOVE SPACES MUST BE FILLED IN OR THE TEST(S) WILL NOT BE PERFORMED

Sample # (Aliquot Label)	Reported To: Date: Time: Clerk:	Received in Lab: (Time Clock Impression)

LAB CENTRAL
EMERGENCY WALK-IN REQUISITION
☒ TUBE-IN (Station #10)

Only the following tests are available on this priority sample.

NO SUBSTITUTIONS OR ADDITIONAL TESTS ALLOWED

CHECK TESTS(S) REQUESTED

☒ Sodium Lvl	_____ mmol/L	☐	Hematocrit
☒ Potassium Lvl	_____ mmol/L	☐	Hemoglobin
☒ Chloride Lvl	_____ mmol/L	☐	Platelet Count
☒ CO2	_____ mmol/L	☒	CBC (WBC, RBC, Hgb, Hct, indices, Plt)
☒ Glucose Random	_____ mg/dl	☒	Protime w/ INR Pt on Coumadin? Y or N
☒ Calcium, Total	_____ mg/dl	☒	PTT Pt on Heparin? Y or N If yes, LMW or UNF?

SEND SEPARATE DOWNTIME REQUISITION FOR BLOOD GAS.

YOU MUST DO THE FOLLOWING:

1. Stamp or write patient demographics, unit #, location, phone #, date and time above.
2. Check test(s) to be done above.
3. Clock in on the front when hand delivered with labeled sample to Lab Central on ground floor.

LABORATORY WILL:

1. Perform analysis and give you the results or phone them to the number above.
2. Enter order and results into the LIS/HIS computers for you.

Medical Necessity: Practitioners should only order tests that are medically necessary for the diagnosis or treatment of a patient. Tests for screening purposes may be ordered but may not be reimbursed.

Documentation: Each laboratory test ordered must have the medical necessity documented on this form. Record reason # next to test name.

(R) = **Reflex Protocol** (See Pathology Laboratory Reference Handbook for details)

PARKLAND HEALTH & HOSPITAL SYSTEM

5201 Harry Hines Blvd., Dallas, TX 75235
Department of Pathology

Laboratory Orders – ER Chart Order Form

MRN: HAR:
Last Name: MRN: 4131790 DOB: 01/01/1984
DOB: LAMBDA,F Adm: 03/23/07
WH / M Age: 23 yrs
Location HAR: 602194488 Dep: EDEAST
CSN: 310183284 Pln:
CSN:

Desired Collect Date	Desired Collect Time	Actual Collect Date	Actual Collect Time
3/23/07	1930		

Ordering Practitioner: Print Name
Practitioner Signature:
ID# 54072 Pager/Phone#:

Circle testing priority if not routine.
Routine Med Emergency

Use Screening Lab Chart Form / Requisition (form 6197) to order screening tests on Medicare patients.

Reason(s) for Test (e.g. chief complaints, signs, symptoms, etc.)
1. GSW
2.
3.

Write Reason number(s) next to Tests Requested

Tr

	CHEMISTRY					FLUIDS	
X	Electrolytes w/ Gap		Lipid Panel		LD	Fluid Type: _____	Cerebrospinal Fluid
	Sodium Lvl		Cholesterol		CK, Total	Body Cell Count w/Diff	CSF Cell Count w/Diff
	Potassium Lvl		Triglycerides		CK-MB with Index	pH, FL	Glucose, CSF
	Chloride Lvl		HDL Cholesterol		Troponin I, Plasma	Cholesterol, FL	Protein, CSF
	CO2		LDL Chol., Direct		Lactate	Triglycerides, FL	Syphilis VDRL Quant, CSF**
X	BUN		Protein, Total		Protein Elp, SER (R)	Creatinine, FL	Cryptococcal Ag**
X	Creatinine Lvl		Albumin Lvl		Iron Lvl	Glucose, FL	CSF Culture with Smear
	Osmolality (measured)		Bilirubin, Total		TIBC	LD, FL	Intrathecal IgG Syn**
X	Glucose Random		Bilirubin, Direct		Folate	Albumin, FL	Oligocional Bands**
	Glucose Fasting		AST		Vitamin B-12	Protein, FL	
	Hemoglobin A1c		ALT		Ferritin	Amylase, FL	(**requires serum & CSF)
X	Calcium, Total		Alkaline Phosphatase		Amylase	Lactate, FL	
X	Phosphorus Lvl		GGT		Lipase	Shake Test, AMN (R)	
X	Magnesium Lvl		Ammonia			L/S Ratio, AMN	
	Uric Acid		BNP		Prealbumin	**URINE**	
	HEMATOLOGY		**COAGULATION**		**BLOOD GASES**	Time Started: Time Finished:	
	WBC	X	Protime w/ INR	X	Blood Gas+Hb Sat, ART	Volume Urine _____ ml.	
	Hemoglobin		Pt on Coumadin? Y or N		Blood Gas+HB Sat, VEN	**Random**	**24 hr**
	Hematocrit	X	PTT		Blood Gas, COA (Cord ART)	X Urinalysis (R)	
	Platelet Count		Pt on Heparin? Y or N		Blood Gas, COV (Cord VEN)	Pregnancy Test, UR	
X	CBC (WBC, RBC, Hgb, Hct & Indices, Plt)		If yes, LMW or UNF?		Temp: _____ °C	Sodium, UR	Sodium, 24H UR
			D-Dimer, Quantitative			Potassium, UR	Potassium, 24H UR
	CBC w/Diff		Fibrinogen Lvl			Chloride, UR	Chloride, 24H UR
	Retic Absolute Count		**IMMUNOLOGY**			Urea Nitrogen, UR	Urea Nitrogen, 24H UR
	Sed Rate (ESR)		Rubella IgG Screen		Acute Hep Serology (R)	Creatinine, UR	Creatinine, 24H UR
	Sickle Cell Prep (R)		Syphilis RPR Screen (R)		Chronic Hep Serology (R)	Creatinine Clearance Ht. _____ in. Wt. _____ lbs.	
	Hgb Electrophoresis (R)		Syphilis Treponemal Ab		Hep B Surface Ag	***requires serum Creatinine Lvl***	
	G6PD, Qual.		*HIV-1 and HIV-2 Abs (R)		Hep B Surface Ab	Glucose, UR	Glucose, 24H UR
	Betke/Fetal Hgb Det		*Signed consent required*		Hep C Ab		Calcium, 24H UR
			HIV-1 RNA Viral Load		Hep A IgM Ab	Phosphorus, UR	Phosphorus, 24H UR
	HORMONES		HIV-1 Ultrasensitive Viral Load		Anti-Nuclear AB (ANA) (R)	Protein, UR	Protein, 24H UR
	TSH		CD4 Helper T-cell		dsDNA Ab (R)	Uric Acid, UR	Uric Acid, 24H UR
	Free T4		CRP		Rheumatoid Factor	Amylase, UR	Amylase, 24H UR
	TSH Reflex (R)		**ANTIBIOTICS**		**THERAPEUTIC DRUGS**	Osmolality, UR	
	Free T3 Index		**Dose Date:**		Acetaminophen Lvl	Protein Elp, UR (R)	Protein Elp, 24H UR (R)
	PTH, Intact		**Dose Time:**		Carbamazepine Lvl	√ Amphetamine Screen, UR (R)	
	hCG, Quantitative		Amikacin Peak		Cyclosporine FPIA	X Barbiturate Screen, UR	
	FSH		Amikacin Trough		Digoxin Lvl	X Benzodiazepine Screen, UR	
	LH		Amikacin Random		Lidocaine Lvl	X Cannabinoid Screen, UR	
	Progesterone Lvl		Gentamicin Peak		Lithium Lvl	X Cocaine-Metabolite, UR (R)	
	Prolactin		Gentamicin Trough		PA & NAPA	X Opiate Screen, UR	
	Cortisol		Gentamicin Random		Phenobarbital Lvl	X Phencyclidine Screen, UR (R)	
	AFP-Tumor Marker		Tobramycin Peak		Phenytoin Lvl	Urine Culture	
	CEA		Tobramycin Trough		Primid+Phenobarb.	☐ Clean Catch ☐ Catheterized ☐ Suprapubic	
	Testosterone Lvl		Tobramycin Random		Quinidine Lvl	**TRANSFUSION SERVICES**	
	MISCELLANEOUS		Vancomycin Trough		Salicylate Lvl	ABORh	Type and Screen OB
	Ethanol, BLD (R)		Vancomycin Random		Theophylline Lvl	Antibody Screen	
	PSA, Total				Valproic Acid Lvl	DAT	

Other test(s):
T+C 4 units PRBC

Medical Necessity: Practitioners should only order tests that are medically necessary for the diagnosis or treatment of a patient. Tests for screening purposes may be ordered but may not be reimbursed.

Documentation: Each laboratory test ordered must have the medical necessity documented on this form. Record reason # next to test name.

(R) = **Reflex Protocol.** See Pathology Laboratory Reference Handbook for details.

ER

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

STAFF PROGRESS NOTES

MRN: 4131790 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 602194488
CSN: 310183284

DO NOT USE					
U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
IU	QD		q.o.d.	MSO4	Lack of leading zero(.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	
3-23-07		SICU R3 Accept Note
23:55		23y/o WM c multiple GSW to (R) hemi thorax, (B) UE, face - majority grazing wounds with open left hand fx taken to OR from ER for exploration. Underwent (B) tube thoracostomys - no blood in chest. Had pericardial window - negative. Exploratory laparotomy - negative for injury. Removal of FB from (R) knee.
		PMHx unknown
		PSHx unknown
		SHx unknown
		HR 104 BP · RR 10 Sat 100%
		Intubated, Sedated
		CTA (B) Tachy ϕm
		S/NT/ND (+)BS Splints to (B) UE
		2+ palp (B) fem/DP/PT
		Dressings to midline - c/d/i
		multiple small lacs to (R) Arm, thorax face.
		A/P 23y/o WM s/p multiple GSW to (R) hemibody. Still concern for (R) UE arterial injury - axillary vs brachial
		Duvel 2 Aygram to eval RUE
		CT Head/Face
		if stable will attempt to extubate in AM.
		Holtmann MD
		32486

Name: MR#:

STAFF PROGRESS NOTES

DO NOT USE

U / IU	Q.D. / QD / q.d.	qd / Q.O.D.	QOD / q.o.d. / qod	MS / MSO4 / MgSO4	Trailing zero (X.0 mg) / Lack of leading zero (.X mg)

DATE	TIME	
3/24/07	540	Respiratory Care Note:
		Pt was placed on CPAP trial
		at 340. RSBI - 24 RR 12 MVE - 5.5, VT - 476
		Pt tolerated a two hour SBT without
		complications. ABG sent results pending.
		P/F = 458 No CPIS due to intubation <48 hr
		[signature]
		RCP 22512
3-24-07		Sick R3
10:05		Pt awake → able to give some history
		PMHx: Denies
		PSHx: Tonsillectomy
		SHx: Denies tob, denies EtOH
		[signature] MD
		52486

52370 (Back) Revised 08/26/05

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

SURGERY
PROCEDURE NOTES

MRN: 4131790 Adm: 03/23/07
LAMBDA, F
DOB: 01/01/1984 23 yrs WH/M
ED EAST
HAR: 602194488
CSN: 310183284

Date: 3/23/07 Time:

Diagnosis:

1. GSW chest
2. GSW abdomen
3. GSW bil upper extremity
4. GSW right knee
5.

Procedure:

1. Bilateral tube thoracostomy
2. Exploratory laparotomy
3. Pericardial window
4. Exploration wound right knee & removal of FB
5.

Faculty Surgeon: *(Please Print)* STAFF

Residents/Fellows:

1. HERSHBERGER, R
2. GILLESPIE, R
3.
4.
5.
6.

Anesthesia: GEA

Estimated Blood Loss:

Tourniquet:

Complication: None

Specimens: FB to scrub nurse/circulator

Condition: Critical but stable

Findings: Exp. lap ⊖, no blood in either chest tube, window ⊖, Ⓡ brachial pressure 90/Ⓛ 108 → needs angio, bullet fragment removed from Ⓡ knee at this time, joint injected hydrogen ⊖, open fx Ⓡ hand → ortho consult intra-op

Postoperative Plan: to SICU, then CT chest & angio RUE

Attestation: I was present for, and supervised all significant portions of this procedure.

Faculty Signature:

Dictation #555633

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

SURGERY
PROCEDURE NOTES

MRN: 4131790 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
ED EAST
HAR: 602194486
CSN: 310183284

Date: 3/23/7	Time:
Diagnosis:	opn Ac S/P GSW
1.	
2.	
3.	
4.	
5.	
Procedure:	(R) Ulnar / shaft - wrist IMD inc bone
1.	
2.	(L) MC shaft opn IMD inc bone
3.	
4.	splinted ulnar shaft
5.	
Faculty Surgeon: *(Please Print)*	Perry
Residents/Fellows:	
1.	GW
2.	EE
3.	
4.	
5.	
6.	
Anesthesia:	
Estimated Blood Loss:	
Tourniquet:	
Complication:	
Specimens:	
Condition:	
Findings:	
Postoperative Plan:	
Attestation: I was present for, and supervised all significant portions of this procedure.	
Faculty Signature:	

050

PARKLAND HEALTH AND HOSPITAL SYSTEM
INTENSIVE CARE UNIT PROGRESS NOTE
ALL CLINICAL NOTES MUST BE DATED, TIMED & SIGNED

Primary Attending:_____ Service:_____

MR#:
NAME: MRN: 4131790 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 602194488
CSN: 319183284

DO NOT USE

U	Q.D.	Q.O.D.	MS	Trailing Zero (X.0 mg)
IU	QD	QOD	MSO4	Lack of Leading Zero (.X mg)
	q.d.	q.o.d.	MgSO4	
	qd	qod		

RESIDENT DOCUMENTATION

HISTORY:
23y/o WM s/p multiple GSW to (R) hemithorax, open (L) hand fx, 9p ex-lap - negative, RUE agram (R).

LAST 24 HOURS:
Extubated this AM.
To floor later today

APACHE IV: _____

MEDICATIONS:
Antibiotics:
Ancef Day 1 of 2
_____ Day ___ of ___
_____ Day ___ of ___
Other:

Infusions:

Family History: _____ ☐ Unable to obtain
Social History: _____ ☐ Unable to obtain ☐ See H & P Dated:
Review of systems: _____ ☐ Unable to obtain
IVF: _____ TPN/TF: _____

Lines:	Site:	Original Stick:	Wire Change:
☒ A-Line	L DP	3-23-07	
☒ Ctrl Line	L IJ	3-23-07	
☐ PA Cath			
☐ CT			
☐ Other			
☒ Foley	☐ ETT/Date	☐ Tracheostomy	

ATTENDING DOCUMENTATION

HISTORY:
Mult GSW to torso

LAST 24 HOURS:
ex-lap
pericardium
colon lacerations
extubated

☐ Attended the patient on rounds, reviewed & amended resident's data, examined patient & coordinated care.
☐ Family contact
☐ 99291 (31-74 minutes): __ Minutes
☐ 99292 x____
☐ 99231 ☐ 99232 ☑ 99233
☐ 94656 (ventilator-initial)
☐ 94657 (ventilator-subsequent)
I was present for and directly supervised or performed (circle):
Reason: Access, Fever, Monitoring, (circle) Resp distress/failure, Hemothorax, Pneumothorax
☐ Arterial Line R L Radial Femoral
☐ Bronchoscopy ☐ with BAL
☐ Cardioversion
☐ Central Line Insert (large bore) site: R L IJ SCV FV
☐ Central Line Insert (triple lumen) site: R L IJ SCV FV
☐ Chest Tube Insert: R____ L____
☐ Defibrillation
☐ Endotracheal Intubation
☐ Pulmonary Arterial Catheter site: R L IJ SCV
☐ Thoracentesis: R____ L____
☐ Tracheostomy (see dictation)
☐ Ultrasound chest FAST
☐ Other:(specify)_____

SYSTEM: Physical Exam/Labs/Hemodynamics

NEUROLOGY/MUSCULOSKELETAL/PSYCHIATRIC:
RASS_____ Pupils_____ GCS 13
Tertiary survey
CPP_____ ICP_____ Pb02_____

CARDIOVASCULAR:
P 96-110 BP 147/65 CVP_____ Pulses_____ Edema_____
P CWP_____ CO_____ CI_____ SVR_____ RVEF_____ EDVI_____
TnI_____ CPK_____ B-NP_____
Do2I_____ VO2I_____ Sv02_____ OER_____

PULMONARY:
Lung Sounds: ☑ Normal ☐ Decreased ☐ Coarse
Secretions_____ CT Output: R 30 L 30
CXR report_____
Ventilator Settings_____ ABG_____
Weaning: CPIS___ RSB___ VE___
RR 11 96% on RA

RENAL/ENDOCRINE/GENITOURINARY:
In 1189 Out 1735 Na 136 K 4.4 Cl 105
CO2 24 Glucose 125 BUN 11 Creatinine 0.79 Ca 6.6
Mg 1.6 Phosphorus 4.0

PROPHYLAXIS:
H2___ Other___
Filter SCD SQH LMWH IV Heparin Other
Last DVT Screen:_____

GASTROINTESTINAL:
BS 0 BM 0 NG-Tube output_____
Drain output_____
Amylase/Lipase___ SGOT___ SGPT___ Bilirubin___
Prealbumin/date_____

HEMATOLOGIC:
Hgb 11.1 Hct 31.6 Platelets 190 pT 11.8
pTT 25.4 Fibrinogen_____

INFECTIOUS DISEASE:
Tmax 36.7 White count 11.4
Positive Cultures w/ date: ☐ BAL_____
☐ Urine_____ ☐ Blood_____
☐ Line_____ ☐ Other_____

DIAGNOSIS

- ☐ CVA - stroke
- ☐ Coma
- ☐ Diabetes insipidus
- ☐ SAH
- ☐ Head Injury
- ☐ Seizures
- ☐ Quadriplegia
- ☐ Paraplegia
- ☐ Multiple Internal Injuries
- ☐ Multiple Fractures
- ☐ Delirium

- ☐ Arrhythmia
- ☐ Atrial fibrillation
- ☐ CHF
- ☐ MI
- ☐ Shock
- ☐ Hypertension
- ☐ Hypervolemia
- ☐ Hypovolemia
- ☐ CAD

- ☐ ARDS
- ☐ Acute Resp Fail
- ☐ Resp. Insufficiency
- ☐ Tracheobronchitis
- ☐ Pleural Effusion
- ☐ COPD
- ☐ Pneumonia
- ☐ Atelectasis
- ☐ Pneumothorax-Traumatic
- ☐ Pneumothorax-Barotrauma

- ☐ Acute renal failure
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Hypernatremia
- ☐ Hyponatremia
- ☐ Hypomagnesemia
- ☐ Hypophosphatemia
- ☐ Hyperkalemia
- ☐ Hypokalemia
- ☐ Metab Acidosis
- ☐ Metab Alkalosis
- ☐ Renal Insufficiency
- ☐ Diabetes
- ☐ Chronic Renal Failure

- ☐ Cholecystitis
- ☐ GI Bleed
- ☐ Pancreatitis
- ☐ Peritonitis
- ☐ Diarrhea
- ☐ Malnutrition-Mild Moderate - Severe
- ☐ Ileus
- ☐ _____

- ☐ Anemia
  - ___Acute blood loss
  - ___Chronic blood loss
- ☐ Thrombocytopenia
- ☐ DVT
- ☐ PE
- ☐ Coagulopathy
- ☐ _____

- ☐ Bacteremia
- ☐ Fever
- ☐ UTI
- ☐ _____
- ☐ BSI
- ☐ SIRS
- ☐ Sepsis
- ☐ Severe Sepsis
- ☐ VAP

RATIONALE & PLAN

For Sedation/Other: _____
☐ Patient meets ICU restraint protocol criteria

For Monitoring, Pressors, Arrhythmias/Other:

For Ventilator Management/Other:_____

For Fluid/Other:_____
Renal Electrolytes:_____
☐ Replete _____
☐ Follow _____

For Prophylaxis:_____

For Feeding/Other:_____
☐ Enteral_____
☐ Parenteral_____

For Transfusion/Other:_____

For Antibiotics/Other: Ancef

Resident Signature: Sarah Oltmanns Resident Printed Name: Oltmanns
ID #: 52436 Date: 3-24-07 Time: 0024

Attending Signature: _____ Attending Printed Name: Goldfeld
ID #: 5146 Date: 3/24/07 Time: _____

050

Abbreviation Page

ABG	Arterial Blood Gas
A-Line	Arterial Line
ARDS	Adult Respiratory Distress Syndrome
BAL	Bronchoalveolar Lavage
BM	Bowel Movement
B-NP	B(rain) Natruretic Peptide
BP	Blood Pressure
BS	Bowel Sounds
BSI	Blood Stream Infection
BUN	Blood Urea Nitrogen
Ca	Calcium
CAD	Coronary Artery Disease
CHF	Congestive Heart Failure
CI	Cardiac Index
Cl	Chloride
CO	Cardiac Output
COPD	Chronic Obstruction Pulmonary Disease
CPIS	Clinical Pulmonary Infection Score
CPK	Creatine Phosphokinase
CPP	Cerebral Perfusion Pressure
CT	Chest Tube
Ctrl Line	Central Line
CXR	Chest X-Ray
CVP	Central Venous Pressure
DO_2I	Oxygen Delivery Index
DVT	Deep Venous Thrombosis
EDVI	End Diastolic Volume Index
ETT	Endotracheal Tube
FAST	Focused Assessment by Sonography in Trauma
FV	Femoral Vein
GI	Gastrointestinal
GCS	Glasgow Coma Scale
Hct	Hematocrit
Hgb	Hemoglobin
ICP	Intracranial Pressure
IVF	Intravenous Fluid
IJ	Internal Jugular
K	Potassium
L	Left
LMWH	Low Molecular Weight Heparin
Mg	Magnesium
MI	Myocardial Infarction
Na	Sodium
NG	Nasogastric
OER	Oxygen Extraction Ratio
PA Cath	Pulmonary Artery Catheter
PbO_2	Brain Oxygenation
P	Pulse
PCWP	Pulmonary Capillary Wedge Pressure
PE	Pulmonary Embolus
pT	Protime
pTT	Partial Thromboplastin Time
RASS	Ramsay Agitation Sedation Score
RESP	Respiratory
R	Right
RSB	Rapid Shallow Breathing
RVEF	Right Ventricular Ejection Fraction
SAH	Subarachnoid Hemorrhage
SBT	Spontaneous Breathing Trial
SCD	Sequential Compression Device
SCV	Subclavian Vein
SGO	Serum Glutamic Oxaloacetic Transaminase
SGPT	Serum Glutamic Pyruvic Transaminase
SIRS	Systemic Inflammatory Response Syndrome
SQH	Subcutaneous Heparin
SVO_2	Mixed Venous Oxygen Saturation
SVR	Systemic Vascular Resistance
TnI	Troponin I
TPN/TF	Total Parenteral Nutrition/Tube Feeds
UTI	Urinary Tract Infection
VAP	Ventilator Associated Pneumonia
VE	Minute Ventilation
VO_2I	Oxygen Consumption Index
W/	With

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

MRN: 4131790 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 602194488
CSN: 310183284

STAFF PROGRESS NOTES

DO NOT USE

U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
IU	QD		q.o.d.	MSO4	Lack of leading zero(.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	
		TNC admit note - trauma 3
3/24/07	1100	This 27 y.o. HM arrived by EMS in police custody s/p multiple GSWs while being apprehended by police. On scene V/S: 110p, 18r 118/86, GCS=9. Pt nasopharyngeal airway placed. Pt made a Level One trauma. OA V/S: 130p, 12r, 92/p, gcs=12. Hct 43.3
		GSW to face, RUE, (L) shoulder/bicep, (R) chest, (R) flank + (R) knee noted. Pt taken to OR c trauma for (B) CTs, ex lap, pericardial window (R) knee GSW exploration + removal of foreign body to (R) knee. I+D of (B) ulna + (L) metacarpal were performed by ortho + then splints placed. Pt taken to SICU, intubated + then on to radiology department for aortagram + brachiocephalic a-gram (both neg for inj.). Pt extubated this AM. Currently, pt in SICU on RA. Tachycardia continues @ ~100s/115. Normotensive. SpO_2 99%. UOP adequate. CT head/face neg. (B) chest tubes to water seal. Clear diet ordered. Hct 43.3 (OA) → 35.2 (OR) → 31.6 (SICU this AM). Injuries to be monitored include (L) distal ulnar shaft fx, (L) distal 1st metacarpal fx, (R) distal ulnar shaft fx + mult wounds. Pt to go to floor today. DVT/GI prophylaxis in place. Pt on county hold. TAC will continue to follow
		Guin MD & RN 22490

Name: MR#:

STAFF PROGRESS NOTES

DO NOT USE

U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
IU	QD		q.o.d.	MSO4	Lack of leading zero (.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	

050

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

HRN: 4131790
LAMBDA,F Adm: 03/23/07
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 602194488
CSN: 310183284

STAFF PROGRESS NOTES

DO NOT USE

U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
IU	QD		q.o.d.	MSO4	Lack of leading zero(.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	
		17 ♂ Trauma post TICU transfer [illegible]
3-24-07		@Acute c/o pain difficulty breathing comfortably
19	30	s/p extubation today
		37.0 120/70 105 16 99% RA
		NAD (B) CT ⌀ leak
		Tachy/Reg Foley 700
		CTA (B)
		soft BS(+) TTP along incision non dist
		wnl
		(B) UE splint/dry/intact
		midline dressing c/d/I
		23 ♂ s/p MVC mult GSW to (R) hemithorax open
		s/p ex lap
		(1) F/U CXR
		(2) cont CT on N.S.
		(3) F/U labs
		cont management per 1° team
		[illegible]
3-25-07		R. T3
		PAT'S issues ON. Pain well controlled
		37.6
		112
		18
		137/82
		NAD
		~~NO~~ 3-25-07 Chest tubes in place (R)
		abd- wnl. tlp along incision site
		BIL/UE edema, intact, midline dsg c/d/I
		23 y/o s/p MVC GSW
		- pull R chest tubes today, CXR 1500
		- PLA [illegible]

050

STAFF PROGRESS NOTES

DO NOT USE				
U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
IU	QD		q.o.d.	MSO4	Lack of leading zero (.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	
3/25	0847	Dr TIII L chest tube pulled, wound dressed & vaseline gauze. ↓ apparent complications. pt tolerated well. will c/s 3pm CXR. Gattaca

Trauma Case Management
Daily Multidisciplinary Review

Team I II (III) NSG Ortho Date: 3/25 Date of Admit: 3/23 Hospital Date: 2

Mechanism Of Injury: GSW Injuries:

Plan Of Care discussed with:

Referrals made:

Plan Of Care/Priorities:

Pt seen + chart reviewed. Tachycardia continues ~110bpm. Normotensive. Afebrile. UOP adequate. pt c/o pain - morphine PCA ordered. (L) CT D/C (R) CT to H_2O seal. 1500 CXR (P). POC (1) Advance diet as TOI? (2) Ortho final rec's? (3) Follow CXR (4) Ambulate - pt remains in county hold. TNC will follow

Case Mgmt Activity:

- [x] Deep Vein Thrombosis prophylaxis
- [x] GI prophylaxis
- Culture data:
- [ ] Seizure prophylaxis
- [ ] Delirium Tremens prophylaxis
- Antibiotic: Day #:
- [ ] Bedside RN Interaction
- [ ] Family/Other Updated
- [x] Financial Self Nutrition: Clear Tube Feeds: Rate: cc/hr Goal: cc/hr

Nurse Clinician: RN Julie McDaniel ID#: 22490

PS 3997 Revised 11/20/02 RTB

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

STAFF PROGRESS NOTES

MRN: 41381780 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 602194488
CSN: 310183284

DO NOT USE

U IU	Q.D. QD q.d.	qd Q.O.D.	QOD q.o.d. qod	MS MSO4 MgSO4	Trailing zero (X.0 mg) Lack of leading zero(.X mg)

DATE	TIME	
3/23/07		R1 T3
	0730	ϕAE, tol clears, ⊕ flatus
		37.4 90-100s 120-130/70-80s CT 20 ϕair leak
		Abd sft, TTP diffusely
		drsg soaked
		BUE splints intact
		131 | 98 | 7 ⟨ 107 ⟩ 7.3 ⟨ 208 3.8 | 29 | 0.7 8-1 2.6 | 1.5 10.3 29.4
		A/P: 1) Reg diet
		2) HUV
		3) 0.5L free H_2O restrict
		4) D/C Ⓡ CT today

5405

Name: MR#:

STAFF PROGRESS NOTES

DO NOT USE					
U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
IU	QD	q.o.d.	MSO4	Lack of leading zero (.X mg)	
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	

Lambda, F
MR# 4131790

Trauma Case Management
Daily Multidisciplinary Review

Team I II (III) NSG Ortho Date: 3/26/07 Date of Admit: 3/23/07 Hospital Date: 3

Mechanism Of Injury: GSW Injuries:

Plan Of Care discussed with:

Referrals made:

Plan Of Care/Priorities:

Pt seen & chart reviewed. Pt remains on SN on county hold. VSS. Pt tol PO. Morphine PCA in place for pain control. Ø c/o pain currently. (R) CT TO H2O seal. Final CXR & D/C (L) CT yest (P). UOP adequate. Hct 29.4 (fr 31.1). WBC stable @ 7.3. Afebrile. Poc (1) D/C PR CT (2) Reg diet to be started (3) OT eval. — TNC will follow — JM

Case Mgmt Activity:

- [X] Deep Vein Thrombosis prophylaxis
- [X] GI prophylaxis
- [ ] Seizure prophylaxis
- [ ] Delirium Tremens prophylaxis
- [ ] Bedside RN Interaction
- [ ] Family/Other Updated
- [X] Financial Self

Culture data: Ø

Antibiotic: _____ Day #: _____

Nutrition: Clears Tube Feeds: _____ Rate: _____ cc/hr Goal: _____ cc/hr

Nurse Clinician: RN Julie McDaniel RN ID#: 22490

PS 3997 Revised 11/20/02 RTB

050

52370 (Back) Revised 08/26/05

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

MRN: 4131790 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 802194488
CSN: 310183284

STAFF PROGRESS NOTES

DO NOT USE					
U IU	Q.D. QD q.d.	qd Q.O.D.	QOD q.o.d. qod	MS MSO4 MgSO4	Trailing zero (X.0 mg) Lack of leading zero(.X mg)

DATE	TIME	
		RESPIRATORY CARE PATIENT DRIVEN PROTOCOL ASSESSMENT
		Patient Name: Luna Location: _____ Date/Time: _____
		This patient has been assessed utilizing Respiratory Care Patient Driven Protocols. According to these protocols, this patient is indicated for:
		☐ **Aerosolized Medication Therapy**
		Recommended medication: _____
		Recommended frequency: _____
		Administered via:
		☐ MDI
		☐ Hand Held Neb
		☐ IPPB
		☐ **Bronchial Hygiene Therapy**
		☐ Chest Percussion/Vibration QID
		☐ Postural Drainage QID
		☐ Chest Percussion/Vibration and Postural Drainage QID
		☐ **Volume Augmentation Therapy**
		☑ Incentive Spirometry TID
		☐ Incentive Spirometry at bedside--instruct only
		☐ IPPB QID
		☐ IPPB with medication (see recommendations above)
		☐ **Pulse Oximetry**
		☐ Continuous Pulse Oximetry
		☐ Intermittent Spot Checks Q4
		☐ **Oxygen Therapy**
		☐ Oxygen per protocol (O2 to keep SaO2 ≥ 92%)
		Therapist Signature: _____ Employee ID#: _____
		Patient must be reevaluated by the physician at least every 72 hours. Please call the Respiratory Care Department at x28193 with any questions pertaining to these protocols.

STAFF PROGRESS NOTES

DO NOT USE

U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
W	QD		q.o.d.	MSO4	Lack of leading zero (.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	
3/27/07	0625	R, T3 Pt's complaints: ↓ pain, ↓ SOB t-37.0 r-18 ⊖foley p-84-100 bp 101-135/65-82 NAD Bandages c/d/I abd-nt, nd soft 3/27 (10.8/31) 7.29 \ 10.3 / 209 — 133 | 98 | 9 — Ca-8.0 29.4 — 3.9 | 30 | 0.72 — Ph-3.1 Mg-1.6 A/P 1) chest tubes removed, f/u final read on CXR 3/27. 2) plan for d/c pending CXR. Shawn RNBSN
3/27/07	1420	TNC - T3 : HD#4 Pt seen, chart reviewed; pt remains on SN on county hold. Febrile 39.2 @ Noon today, no new UKC. (R) CT removed this AM, post CXR pending final read. (+) Flatus, ⊘ BM per pt. Remains on 0.5L fluid restriction — Na+ 133 ↑ from 131. Tolerating reg. diet @ N/V. Continued pain to b/l at UE's, po Lorcet for pain relief. UA sent 2° to febrile, motrin for fever PRN. OT following. Plan: pain control, await BM, await CXR results, then Discharge to county hold. Shawn McLaughlin RN - TNC 24971

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

STAFF PROGRESS NOTES

MRN: 4131790 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 602194488
CSN: 310183294

DO NOT USE

U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
IU	QD		q.o.d.	MSO4	Lack of leading zero(.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	
		R3 Surgery
3/27/07	1940	Pt seen & examined by me
		Doing well. Tolerating PO. ⊕BM. Voiding
		Tolerating pain. c/o mild pain at CT exit site.
		Tm 39.2 earlier this AM resolved
		HR96 RR20 BP 105/57 Sat 98%
		AAO x3, NAD
		RRR
		CTAB
		(B) UE splints/dressings removed. All wounds
		s̄ erythema/drainage
		abdom. wound stapled c/d/i, ∅ peritonitis
		AM Na 137 from 131
		ua c̄ ⊕LE, ⊕WBC
		Repeat pCXR - ∅ PTX
		Imp: 23 yo s/p GSW to (R) chest, abd,
		(B) UE. Doing well
		Plan: 1) D/C to jail hospital ward
		c̄ Q 40 US
		2) RTC Thursday 3/29/07
		3) Cipro for UTI
		D/W Staff Dr. Thal who agrees [signature] 5242

050

52370 (Front) Revised 08/26/05

Name: MR#:

STAFF PROGRESS NOTES

DO NOT USE

U	Q.D.	qd	QOD	MS	Trailing zero (X.0 mg)
U	QD		q.o.d.	MSO4	Lack of leading zero (.X mg)
	q.d.	Q.O.D.	qod	MgSO4	

DATE	TIME	

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

STAFF PROGRESS NOTES

MRN: 4131790 Adm: 03/23/07
LAMBDA,F
DOB: 01/01/1984 23 yrs WH/M
TWO N TRAUMA SURG ICU D
HAR: 602194488
CSN: 310193284

DO NOT USE
U IU | Q.D. QD q.d. | qd Q.O.D. | QOD q.o.d. qod | MS MSO4 MgSO4 | Trailing zero (X.0 mg) Lack of leading zero(.X mg)

DATE	TIME	
		R3 Surgery
3/27/07	1940	Pt seen & examined by me
		Doing well. Tolerating PO. Voiding
		Tolerating pain. C/o mild pain w CT ext site.
		Tm 39.2 earlier this AM resolved
		HR96 RR20 BP 165/57 Sat 97%
		AAO x3, NAD
		RRR
		CTAB
		(R) LE splint/dressing removed. All wounds c erythema/drainage
		wdsm wound stapled c/d/i, ⊘ pertinent
		AM Na 137 From 131
		Wk c ⊕LE, ⊕WBC
		Repeat pCXR - ⊘PTX
		Impr: 23 yo s/p GSW to (R) chest, abd, (R) LE. Doing well
		Plan: 1) D/C to jail hospital ward c Q4O VS
		2) RTC Thursday 3/29/07
		3) Lipro for UTI
		D/W Staff Dr. Thal who agrees

J. Han
5240

050

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

MRN: 4131790
RUIZ, WESLEY LYNN Adm: 03/23/07
DOB: 11/20/1979 27 yrs WH/M
FIVE N TRAUMA
HAR: 60219448
CSN: 310183284

PHYSICAL MEDICINE AND REHABILITATION
OCCUPATIONAL THERAPY

HAND/UPPER EXTREMITY EVALUATION FORM

☒ Inpatient ☐ Outpatient ☒ Initial Evaluation ☐ Periodic Evaluation

Date: 3-26-07 Date of Injury: 3-22-07 Date of Surgery: 3-22

Injured Extremity: ☒ Right ☒ Left Hand Dominance: ☒ Right ☐ Left

Diagnosis: (relevant Occupational Therapy order) S/P multiple GSW, (B) open ulna fx RUE GSW 4, (R) axilla GSW -2, GSW (L) SHLDR, GSW (L) Bicep

Relevant Health Risk Factors:

Medications: PMHx: Tonsillectomy, Cocaine abuse

Pain: 0 No pain 1 2 Mild 3 4 Moderate 5 6 Severe 7 8 Very Severe 9 10 Worst Possible

Pain Description: "sore all over"

Pain Related Functional Deficit: Pt uses PCA pump currently supine in Bed

☒ See reverse side of form for specific measurements.

Anatomical Limitations: MULTIPLE GSW, (L) 1st metacarpal fx (B) ulnar fx S (R) Boxers fx

Functional Limitations: (Activities of Daily Living/Work/Leisure) Pt not perform any ADLs at this time

Patient Goals: return to PLOF

Treatment Goals:

☒ Splinting (Protective/Corrective/Functional) ulnar gutter splint (R) 2° ulna/5th MCP fx (L) TH spica splint 2° 1st metacarpal fx

☒ In 1-2 weeks patient will improve Active Range Of Motion of non-affected digits

☐ In weeks patient will improve Passive Range Of Motion

☐ In weeks patient will increase strength

☐ In weeks patient will increase endurance

☐ In weeks patient will decrease edema

☒ In 1-2 weeks patient will decrease pain to increase function with ADLs rated at 3/10

☐ In weeks patient will learn education/home program

☒ Other Pt will complete toilet task at MOD (I) in 1 wk

Treatment Plan: times per week for 1-2 weeks x LOS in hospital for ADLs, Splinting, and ROM

Therapist's Signature: [signature] OTR ID #: 2654 Pager #:

317B

623 (Front) Revised 03/22/05

Name: NUM-TOUCH/KF (L) H Medical Record Number:

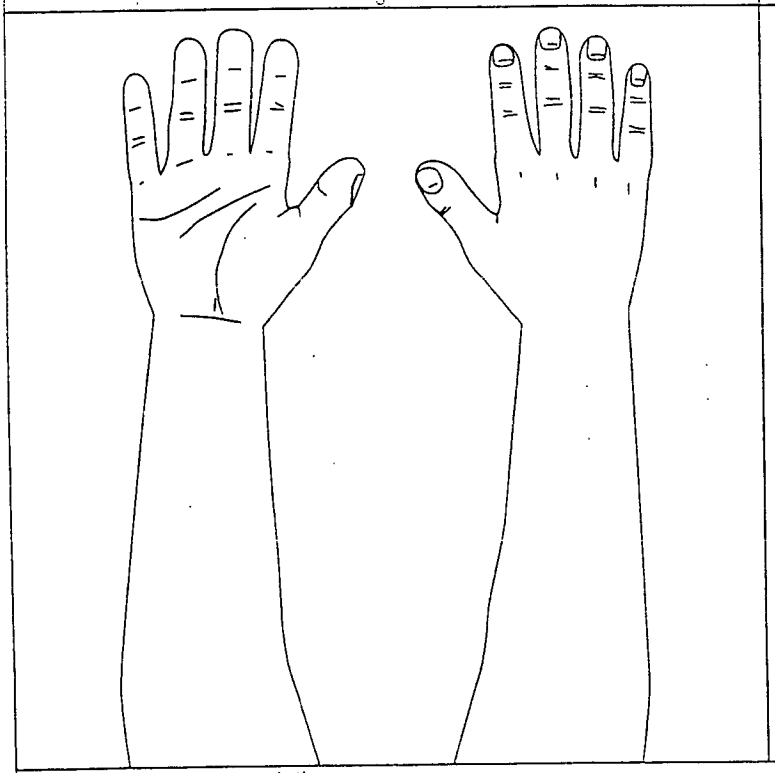
Finger Range of Motion:

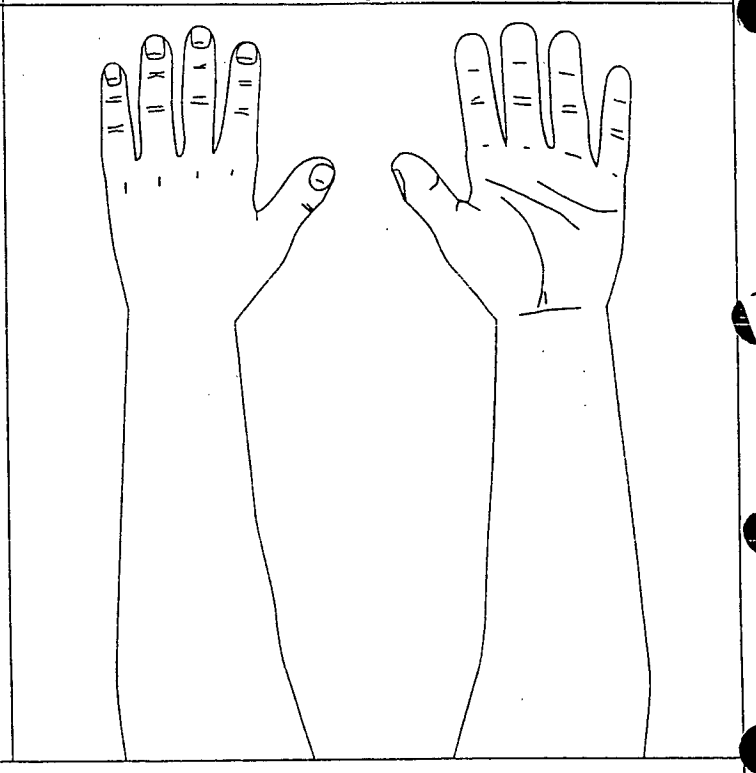
	Active/Passive Right/Left					Active/Passive Right/Left				
	Index	Middle	Ring	Small	Thumb	Index	Middle	Ring	Small	Thumb
Metacarpalphalangeal	minimal	movement			/	/	/	/	/	/
Pr… Interphalangeal	/	/	/	/	/	/	/	/	/	/
Di… erphalangeal	to non-affected joints 2°					/	/	/	/	/
Distal Palmar Crease	Pain and edema									

Upper Extremity Evaluation	**Range of Motion**		**Muscle Strength**		**Edema:**
Active/Passive	Right	Left	Right	Left	Location:
Shoulder Extension/Flexion	NT	NT	NT	NT	
Shoulder Abduction/Adduction	/	/			
Should Horizontal Abduction/Adduction	/	/			Description:
Shoulder Internal/External Rotation	/	/			
Elbow Extension/Flexion	/	/			
Forearm Supination/Pronation	/	/			Measurement:
Wrist Extension/Flexion	/	/			
Wrist Radial/Ulnar Deviation					

Hand Muscle Strength:

Grip Strength	NT /	/	Lateral Pinch Right/Left	NT /	/
	Right		Tripoint Pinch Right/Left	/	/
				Right	





Topographical Characteristics:

Sensory Deficits: grossly intact to light touch

Orthotics: Splint Applied: (B) splints Purpose:

Position: See reverse Wear:

Therapist's Signature: ID #: Pager #:

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

PHYSICAL MEDICINE AND REHABILITATION

OCCUPATIONAL THERAPY
DAILY NOTE

MRN: 4131790
RUIZ,WESLEY LYNN
DOB: 11/20/1979 27 yrs WH/M
FIVE N TRAUMA
HAR: 602194486
CSN: 310183284
Adm: 03/23/07

☒ INPATIENT ☐ OUTPATIENT

DATE (MONTH-DAY-YEAR)	TIME	PHYSICAL TEST PERFORMANCE @ 15 MIN	O.T. INITIAL EVALUATION	O.T. PERIODIC EVALUATION	O.T. ORTHOTIC FIT/TRAINING	O.T. ORTHOTIC CHECKOUT	PARAFFIN BATH PER BODY AREA	VASOPNEUMATIC DEVICE	COGNITIVE SKILLS @ 15 MIN	ELECTRICAL STIMULATION SUPERVISED @ 15 MIN	FUNCTIONAL ACTIVITIES @ 15 MIN	MASSAGE @ 15 MIN	NEUROMUSCULAR REEDUCATION @ 15 MIN	THERAPEUTIC PROCEDURE @ 15 MIN	SELF CARE @ 15 MIN	ULTRASOUND @ 15 MIN	IONTOPHORESIS @ 15 MIN	MANUAL THERAPY TECHNIQUES @ 15 MIN	WHIRLPOOL (FLUIDOTHERAPY) @ 15 MIN	THERAPEUTIC PROCEDURE GROUP	COMMUNITY REINTEGRATION @ 15 MIN	CONTRAST BATHS @ 15 MIN				THERAPIST'S INITIALS
3-26-07	1:45 2:45		(4)																						8MS
		Eval completed - see form 317B.																							
3-27-07	1045-1100 total min				1																				
		Pt. seen reporting 7/10 pain in UE's and chest. Pt. splints removed and both ± adequate for Pt. reports to be ambulating to bathroom for																							
		sc and cleaning self.																							LH

INITIALS	THERAPIST'S SIGNATURE	INITIALS	THERAPIST'S SIGNATURE
8MS	OTR 2638	LH	Heather Horany OTR 26385/3333

PS 324 (Front) Revised 08/09/02 RTB

☐ INPATIENT ☐ OUTPATIENT

DATE (MONTH- YEAR)	TIME	PHYSICAL TEST PERFORMANCE @ 15 MIN	O.T. INITIAL EVALUATION	O.T. PERIODIC EVALUATION	O.T. ORTHOTIC FIT/TRAINING	O.T. ORTHOTIC CHECKOUT	PARAFFIN BATH PER BODY AREA	VASOPNEUMATIC DEVICE	COGNITIVE SKILLS @ 15 MIN	ELECTRICAL STIMULATION SUPERVISED @ 15 MIN	FUNCTIONAL ACTIVITIES @ 15 MIN	MASSAGE @ 15 MIN	NEUROMUSCULAR REEDUCATION @ 15 MIN	THERAPEUTIC PROCEDURE @ 15 MIN	SELF CARE @ 15 MIN	ULTRASOUND @ 15 MIN	IONTOPHORESIS @ 15 MIN	MANUAL THERAPY TECHNIQUES @ 15 MIN	WHIRLPOOL (FLUIDOTHERAPY) @ 15 MIN	THERAPEUTIC PROCEDURE GROUP	COMMUNITY REINTEGRATION @ 15 MIN	CONTRAST BATHS @ 15 MIN				THERAPIST'S INITIALS

INITIALS	THERAPIST'S SIGNATURE	INITIALS	THERAPIST'S SIGNATURE

PS 324 (Back) Revised 08/09/02 RTB

Parkland
Health & Hospital System
Department of Pathology
5201 Harry Hines Blvd. • Dallas, Texas 75235

MR#: 4131790
Patient: RUIZ, WESLEY LYNN
DOB: 11/20/1979 Age: 27 years Sex: Male
HAR: 602194488 CSN: 310183284
Admit: 03/23/2007 Discharge: 03/27/2007
Location: 5N TRA
Practitioner: Purdue, Gary F.

Transfusion Services

ABORh Type

Collected Date 03/23/2007
Collected Time 19:39:00

Procedure
ABORh Manual A Pos

Antibody Screen

Collected Date 03/23/2007
Collected Time 19:39:00

Procedure
Ab Screen Manual. Negative ABSC

Hematology

Cell Count/Differential

	Procedure	WBC	RBC	Hemoglobin	Hematocrit	MCV	MCH
	Units	x10(9)/L	x10(12)/L	g/dL	%	femtoliters	pg
	Ref Range	3.90 - 10.70	4.27 - 5.99	13.2 - 16.9	39.6 - 50.2	76.2 - 98.6	24.6 - 33.4
03/26/2007	00:36:00	7.29	**3.31 L**	**10.3 L**	**29.4 L**	88.8	31.1
03/24/2007	00:25:00	9.55	**3.47 L**	**10.8 L**	**31.1 L**	89.6	31.1
03/23/2007	23:40:00	**11.46 H**	**3.50 L**	**11.1 L**	**31.6 L**	90.3	31.7
03/23/2007	20:15:00	**21.71 H**	**3.93 L**	**12.3 L**	**35.2 L**	89.6	31.3
03/23/2007	19:39:00	**22.53 H**	4.84	15.2	43.3	89.5	31.4

	Procedure	MCHC	RDW-CV	Platelet	MPV	Cells Counted	Neutro Abs
	Units	g/dL	%	x10(9)/L	femtoliters		x10(9)/L
	Ref Range	31.6 - 35.4	11.5 - 15.0	174 - 404	9.4 - 12.9		1.80 - 7.70
03/26/2007	00:36:00	35.0	12.5	208	9.6		
03/24/2007	00:25:00	34.7	12.5	199	9.6		7.22
03/23/2007	23:40:00	35.1	12.6	190	9.7		
03/23/2007	20:15:00	34.9	12.5	204	9.5		**17.63 H**
03/23/2007	19:39:00	35.1	12.6	263	9.8	100	

Parkland
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Department of Pathology
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MR#: 4131790
Patient: RUIZ, WESLEY LYNN
DOB: 11/20/1979 Age: 27 years Sex: Male
HAR: 602194488 CSN: 310183284
Admit: 03/23/2007 Discharge: 03/27/2007
Location: 5N TRA
Practitioner: Purdue, Gary F.

Hematology

Cell Count/Differential

	Procedure	Lymphs Abs	Monos Abs	Eos Abs	Basos Abs	Neutro Pct	Lymphs Pct
	Units	x10(9)/L	x10(9)/L	x10(9)/L	x10(9)/L	%	%
	Ref Range	1.00 - 4.80	0.00 - 1.07	0.00 - 0.54	0.00 - 0.21	36 - 72	20 - 51
03/24/2007	00:25:00	**0.88 L**	**1.40 H**	0.04	0.01		
03/23/2007	20:15:00	1.48	**2.52 H**	0.05	0.03		
03/23/2007	19:39:00					**73 H**	**15 L**

	Procedure	Monos Pct	Myelocytes Pct	RBC morphology
	Units	%	%	
	Ref Range	4 - 11		
03/23/2007	19:39:00	11	1	No Abnormality

Coagulation

Coagulation-Routine

Collected Date	03/23/2007	03/23/2007	03/23/2007		
Collected Time	23:40:00	20:15:00	19:39:00		
Procedure				Units	Ref Range
Protime	11.8	11.3	10.6	sec	9.2 - 12.8
INR *	1.2	1.1	1.1		0.9 - 1.3
PTT,New *	25.4	25.0	**22.6 L**	sec	23.5 - 33.5

03/23/2007 19:39:00 INR:
The INR is intended for patients on long-term, stable, oral anticoagulation therapy. INR values should approximate 2.0-3.0 in most cases and 2.5-3.5 for higher intensity of anticoagulation.

03/23/2007 19:39:00 PTT,New:
For monitoring unfractionated heparin therapy with PTT, therapeutic range is 50-80 seconds.

Parkland
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MR#: 4131790
Patient: RUIZ, WESLEY LYNN
DOB: 11/20/1979 Age: 27 years Sex: Male
HAR: 602194488 CSN: 310183284
Admit: 03/23/2007 Discharge: 03/27/2007
Location: 5N TRA
Practitioner: Purdue, Gary F.

General Blood Chemistry

	Procedure	Sodium	Potassium	Chloride	CO2	Anion Gap	Glucose Random
	Units	mmol/L	mmol/L	mmol/L	mmol/L	mmol/L	mg/dL
	Ref Range	135 - 145	3.6 - 5.0	98 - 109	22 - 31	6 - 16	65 - 200
03/27/2007	00:45:00	**133 L**	3.9	98	30	**5 L**	110
03/26/2007	00:36:00	**131 L**	3.8	98	29	**4 L**	107
03/24/2007	03:25:00	136	4.4	105	24	7	128
03/24/2007	00:25:00	**131 L**	4.2	99	25	7	103
03/23/2007	23:40:00	136	**5.4 H**	106	24	6	127
03/23/2007	20:15:00	139	3.9	107	24		119
03/23/2007	19:39:00	138	4.2	106	22	10	155

	Procedure	Creatinine	BUN	Calcium, Total	Phosphorus	Magnesium	pH, BLD *
	Units	mg/dL	mg/dL	mg/dL	mg/dL	mEq/L	
	Ref Range	0.60 - 1.20	7 - 21	8.4 - 10.2	2.4 - 4.5	1.4 - 1.8	
03/27/2007	00:45:00	0.72	9	**8.0 L**	3.1	1.6	
03/26/2007	00:36:00	0.72	7	**8.1 L**	2.6	1.5	
03/24/2007	03:25:00	0.79	11	**6.6 L**	4.0	1.6	
03/24/2007	00:25:00	0.74	7	**7.7 L**	2.7	1.6	
03/23/2007	23:40:00	0.78	11	**6.2 L**	**2.2 L**	1.5	
03/23/2007	20:15:00						7.44
03/23/2007	20:15:00			**7.4 L***			
03/23/2007	19:39:00	1.05	14	9.1	2.9	1.5	

03/23/2007 20:15:00 pH, BLD:
Reference Range:
pH, Arterial 0 - 2 yrs 7.30 - 7.40
2 yrs - 150 yrs 7.34 - 7.44

pH, Venous 0 - 150 yrs 7.31 - 7.41

03/23/2007 20:15:00 Calcium, Total:
Critical Value called to dr stoos ID# md on 3/23/2007 21:07 . Repeated back to the caller? y.

	Procedure	Calcium, Ion	Sodium, BLDA	Potassium, BLDA	Chloride, BLDA
	Units	mg/dL	mmol/L	mmol/L	mmol/L
	Ref Range	4.6 - 5.4	137 - 145	3.6 - 5.0	101 - 111
03/23/2007	22:00:00		137	5.0	105
03/23/2007	20:15:00	**4.3 L**	139	4.0	107

Parkland
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MR#: 4131790
Patient: RUIZ, WESLEY LYNN
DOB: 11/20/1979 Age: 27 years Sex: Male
HAR: 602194488 CSN: 310183284
Admit: 03/23/2007 Discharge: 03/27/2007
Location: 5N TRA
Practitioner: Purdue, Gary F.

General Blood Chemistry

	Procedure	Glucose, BLDA
	Units	mg/dL
	Ref Range	65 - 110
03/23/2007	22:00:00	**115 H**
03/23/2007	20:15:00	**113 H**

Blood Gas

	Procedure	pH, ART	pCO2, ART	pO2, ART	HCO3, ART	O2 Sat, ART
	Units		mmHg	mmHg	mmol/L	%
	Ref Range	7.34 - 7.44	35 - 45	75 - 100	22 - 26	95 - 98
03/24/2007	05:44:00	7.38	**46 H**	**223 H**	**27 H**	**100 H**
03/23/2007	23:40:00	7.39	40	**458 H**	24	**100 H**
03/23/2007	22:00:00	7.41 *	36	**246 H**	23	**100 H**
03/23/2007	20:15:00	7.44	**33 L**	**255 H**	22	**100 H**

03/23/2007 22:00:00 pH, ART:
Corrected from 7.41 on 03/23/2007 22:26:52 by Jacob, Mini Mathew

	Procedure	FO2 Hb, ART	O2 Content, ART	Base Exc, ART	Hemoglobin, BG
	Units	%	mL/dL	mmol/L	g/dL
	Ref Range	94 - 99	18 - 22	-2.4 - 2.3	13.2 - 16.2
03/24/2007	05:44:00	96	**16 L**	1.7	**11.2 L**
03/23/2007	23:40:00	97	**17 L**	-0.6	**11.2 L**
03/23/2007	22:00:00	97	**16 L**	-1.1	**11.6 L**
03/23/2007	20:15:00	96	**17 L**	-1.2	**12.2 L**

	Procedure	Pt Temp
	Units	
	Ref Range	
03/24/2007	05:44:00	Corrected to 37 degC
03/23/2007	23:40:00	35.9
03/23/2007	22:00:00	35.1
03/23/2007	20:15:00	35.5
03/23/2007	20:15:00	35.5

Parkland
Health & Hospital System
Department of Pathology
5201 Harry Hines Blvd. • Dallas, Texas 75235

MR#: 4131790
Patient: RUIZ, WESLEY LYNN
DOB: 11/20/1979 Age: 27 years Sex: Male
HAR: 602194488 CSN: 310183284
Admit: 03/23/2007 Discharge: 03/27/2007
Location: 5N TRA
Practitioner: Purdue, Gary F.

Urinalysis

Collected Date 03/27/2007
Collected Time 13:36:00

Procedure		Units	Ref Range
Color	DK YELLOW		
Clarity	Cloudy		
Spec Gr	1.022		1.002 - 1.030
pH	**8.0**		5.0-7.0
Protein	Trace		Neg-Trace
Glucose	Negative		Negative
Ketones	Negative		Negative
Bilirubin	Negative		Negative
Blood	Negative		Negative
Nitrite	Negative		Negative
Urobilinogen	1.0	EHR Units/dL	0.2-1.0
Leukocytes	**Small**		Negative
RBC, UA	0-2 /HPF		0-3
WBC, UA	**6-10 /HPF**		0-5
Squam Epithel	0-2 /HPF		0 - 4
Bacteria	None		

Special Chemistry

Procedure	Lactate	Lactate, BLDA
Units	mmol/L	mmol/L
Ref Range	0.7 - 2.1	0.0 - 1.3
03/23/2007 23:40:00	2.1	
03/23/2007 20:15:00		**2.2 H**

Cancelled Orders

Collected Date	Collected Time	Procedure	Cancel Reason
03/23/2007	19:39:00	ABORh	Order modified in lab
03/23/2007	19:39:00	Antibody Screen	Order modified in lab
03/23/2007	19:39:00	Differential Automated	System Cancel

Parkland
Health & Hospital System
Department of Pathology
5201 Harry Hines Blvd. • Dallas, Texas 75235

MR#: 4131790
Patient: RUIZ, WESLEY LYNN
DOB: 11/20/1979 Age: 27 years Sex: Male
HAR: 602194488 CSN: 310183284
Admit: 03/23/2007 Discharge: 03/27/2007
Location: 5N TRA
Practitioner: Purdue, Gary F.

Cancelled Orders

Collected Date	Collected Time	Procedure	Cancel Reason
03/23/2007	22:00:00	Blood Gas Hemoglobin Saturation, Arterial	Duplicate Order
03/23/2007	22:00:00	Chloride, Blood Arterial	Duplicate Order
03/23/2007	22:00:00	Glucose, Blood Arterial	Duplicate Order
03/23/2007	22:00:00	Potassium, Blood Arterial	Duplicate Order
03/23/2007	22:00:00	Sodium, Blood Arterial	Duplicate Order
03/24/2007	03:25:00	Chloride Level	Duplicate Order
03/27/2007	23:30:00	Hematocrit	DISCHARGE
03/27/2007	23:30:00	Hemoglobin	DISCHARGE

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **RUIZ, WESLEY LY**
MRN: **000004131790**
DOB: 11/20/1979

Patient Type: Inpatient
Patient Location: SICU-Room 200d
Requesting Location: 2N SICU D
Ordering Physician: Shahid Shafi MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9: 862.9

Exam(s):

SP Arteriogram-Extremity Unilateral	3/24/2007 00:49	P: 22044149
SP Aortgm-Thoracic-Body	3/24/2007 00:49	P: 22044151
SP Brachiocephalic 2nd order	3/24/2007 00:49	P: 22044117

Reason For Exam: wm y/o multiple gsw to rue, rt thorax w/decreased brachial pressure and 2 hematomas. Please evaluate for vascular injury.

*****Final Report*****

Procedure: Aortic arch and the right upper extremity arteriogram.

Clinical History: 23 years old male with gunshot wound.

Procedure: After obtaining informed consent, Patient was placed supine on the fluoroscopy table. Patient's right groin was prepped and draped in sterile fashion. 1% lidocaine was used for local anesthesia. Access into the right common femoral artery was obtained with a micropuncture set. A 5 French sheath was placed. A 5 French pigtail catheter was advanced over 0 .035 inch guidewire under fluoroscopy guidance to the ascending aorta. The aortic arch arteriogram was performed in LAO and RAO projections. Then the pigtail catheter was changed to a 5 French H1 catheter. The catheter was selected positioned to the distal right subclavian artery. The right upper extremity arteriogram was performed. The catheter and sheath was removed. Hemostasis was achieved by manual compression. Patient tolerated procedure well without immediate complications.

Findings: The aortic arch and it's major branches are normal without anatomical variation or pseudoaneurysm or active contrast extravasation. Multiple bullet fragments were noted in the right shoulder and upper extremity. The right subclavian artery, axillary artery, brachial artery are all patent without aneurysm or active contrast extravasation. The radial artery, interosseous artery and ulnar artery are all patent with a patent palmar arch.

Impression:
No angiographic evidence of artery injuries of the aortic arch and right upper extremity.

I personally present and conclusions above report.

Report Dictated by: Ruizong Li MD, Resident
Electronically Signed by: Jorge E. Lopera MD

Date transcribed: 3/24/2007 02:56:24
Transcribed By: pow

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: RUIZ, WESLEY LY
MRN: 000004131790
DOB: 11/20/1979

Patient Type: Emergency
Patient Location: ED EAST
Requesting Location: ER East
Ordering Physician: Shahid Shafi MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):
Chest Single View OR 3/23/2007 19:57 P: 22043959

Reason For Exam: CHEST TUBE PLACEMENT

Final Report

Portable chest 3/23/07 2138 hours is made available on 3/30/07 after numerous subsequent chest x-rays have been reported.

Bilateral chest tubes are present with question of tiny residual apical pneumothorax. Bilateral chest tubes are present. Small area of pulmonary infiltrate right lower perihilar region. Heart size normal. Endotracheal tube ends 6 cm above carina. The catheter overlies the expected location of the left jugular system. Please see reports of subsequent chest x-ray which have already been reported.

Electronically Signed by: Robert H. Epstein MD

Date transcribed: 3/30/2007 14:43:20
Transcribed By: lfreem

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **RUIZ, WESLEY LY**
MRN: **000004131790**
DOB: 11/20/1979

Patient Type: Inpatient
Patient Location: 5N Room-502
Requesting Location: 5N GENERAL SURGERY
Ordering Physician: Lucy Brooks Wallace MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9: 959.9

Exam(s):
Chest-1 View DX 3/24/2007 23:00 P: 22044672

Reason For Exam: ,multi gsw to chest, eval for pneumothroax

*****Final Report*****

Clinical History : Gunshot wound to chest

Findings:

Comparison : 3/24/2007 at 1758 hours, 3/23/2007.

Single semi upright AP view of the chest was obtained.

Cardiac size is within normal limits and stable. Bilateral chest tubes have been placed, unchanged. No residual pneumothorax is seen bilaterally. No effusion identified.

Multiple radiopaque metallic densities are seen overlying the right axillary soft tissues, compatible with gunshot wound injury.

Impression :

1. No acute interval change. No visible evidence of pneumothorax seen.

I personally reviewed the study and the report above and concur.

Report Dictated by: Wendy Tammy Chuang MD, Resident
Electronically Signed by: George C. Curry MD

Date transcribed: 3/25/2007 08:48:35
Transcribed By: pow

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **RUIZ, WESLEY LY**
MRN: **000004131790**
DOB: 11/20/1979

Patient Type: Inpatient
Patient Location: 5N Room-502
Requesting Location: 5N GENERAL SURGERY
Ordering Physician: Stacy L. Lee MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9: 518.0

Exam(s):
Chest-1 View DX 3/27/2007 10:21 P: 22047195

Reason For Exam: ,ptx

*****Final Report*****

Chest AP portable semi upright on 3/27/2007. Completion time 1044 hours. Comparison 3/26/2007 and 3/25/2007. Small pneumothorax noted on the previous film is no longer seen. Subsegmental atelectasis at left base unchanged. There has been further clearing of the right lung. Cardiomediastinal structures stable. Buckshot pellet over left chest. Multiple gunshot fragments in right chest wall and right shoulder.

Impression:

No pneumothorax is identified.

Electronically Signed by: Michael W. Laughlin MD

Date transcribed: 3/27/2007 14:05:26
Transcribed By: lfreem

LAR 10-24-28 BND 302-1

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

PATIENT DEMOGRAPHIC UPDATE FORM

Lambda, F
MR# 4131190
90D
MEDICAL RECORD NUMBER:

Refer to the Patient Demographic Updates Administrative Procedure for Form Instructions

INITIAL DEMOGRAPHIC INFORMATION		UPDATED DEMOGRAPHIC INFORMATION	
LAST NAME:	Lambda	LAST NAME:	Ruiz
FIRST NAME:	F	FIRST NAME:	Wesley
MIDDLE NAME:		MIDDLE NAME:	Lynn
Suffix: (Jr, Sr, II)		Suffix: (Jr, Sr, II)	
Date of Birth: (Month/Day/Year)	11/1/84	Date of Birth: (Month/Day/Year)	11/20/79
Gender:	Male Female	Gender:	(Male) Female
Race (Non-Key):	Level One Patient	Race (Non-Key):	Hispanic
Social Security Number:		Social Security Number:	
Marital Status:		Marital Status:	
State of Birth:		State of Birth:	
Maiden Name:		Maiden Name:	
Mother's Maiden Name:		Mother's Maiden Name:	
Street Number & Name:		Street Number & Name:	
Apartment Number:		Apartment Number:	
City:		City:	
State:		State:	
Zip Code:		Zip Code:	
Home Phone:		Home Phone:	
Supporting Documentation?	Yes No Type:		

EMPLOYEE CONTACT DATA

EMPLOYEE'S NAME	EMPLOYEE ID#	FACILITY, DEPARTMENT AND AREA NAME
Julie McDaniel	22490	Trauma
EMPLOYEE'S DIRECT EXTENSION AND PAGER		DATE FORM COMPLETED
8268	A60	3/24/07

657 Revised 12/28/04 SRC

5N

620

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **RUIZ, WESLEY LY**
MRN: **000004131790**
DOB: 11/20/1979

Patient Type: Inpatient
Patient Location: 5N Room-502
Requesting Location: 5N GENERAL SURGERY
Ordering Physician: Constance Q. Zhou MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9: 512.8

Exam(s):
Chest-1 View DX 3/26/2007 15:31 P: 22045548

Reason For Exam: ,chest tube

*****Final Report*****

Chest AP portable upright on 3/26/2007 at 1605 hours. Comparison: 3/25/2007 and 3/24/2007.

Since previous study, right chest tube has been removed. Possible small right apical pneumothorax seen projecting over right second posterior intercostal space. Housestaff notified on 3/27/2007 at approximately 0930 hours. Improved aeration with clearing of some opacity from the right lower lung zone. Subsegmental atelectasis at left base which is otherwise clear. Cardiomediastinal structures stable. BB shot overlies the left chest.

Impression:

Removal of right chest tube. Possible small right apical pneumothorax.

Electronically Signed by: Michael W. Laughlin MD

Date transcribed: 3/27/2007 09:19:14
Transcribed By: rcurno

620

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **RUIZ, WESLEY LY**
MRN: **000004131790**
DOB: 11/20/1979

Patient Type: Inpatient
Patient Location: 5N Room-502
Requesting Location: 5N GENERAL SURGERY
Ordering Physician: Stacy L. Lee MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9: 861.21
959.11
V58.82

Exam(s):
Chest-1 View DX 3/25/2007 15:31 P: 22044965

Reason For Exam: ,after chest tube removal

*****Final Report*****

Single view the chest 3/25/2007.
Comparison: 3/24/2007.

History: Status-post chest tube removal.

Findings: Upright frontal view of the chest demonstrates interval extraction of a left-sided chest tube. There is a minimal amount of subcutaneous emphysema; there is no evidence pneumothorax.

The cardiac silhouette is normal. There's no evidence for focal consolidation.

On the right, there is a chest tube placed with its distal tip at the level of the hilum. There is increased radiodensity within the inferolateral right chest: question pulmonary contusion. There are bullet fragments in the right axilla and a buckshot pellet overlying the lower left lung.

Impression:
1. Interval removal of a left-sided chest tube; there is no evidence for pneumothorax.
2. Right-sided chest tube, stable in positioning in the interval.
3. Findings suggestive of pulmonary contusion to the lower right chest.
4. Bilateral findings consistent with gunshot wounds.

Electronically Signed by: Gregory A. Millnamow MD

Date transcribed: 3/26/2007 11:32:27
Transcribed By: pow

5N

620

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: LAMBDA, F
MRN: 000004131790
DOB: 1/1/1984

Patient Type: Emergency
Patient Location: ~~ED EAST~~ 502-1
Requesting Location: ER East
Ordering Physician: John F. Marcucci MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):
Abdomen, KUB ER

3/23/2007 19:57 P: 22043955

Reason For Exam: ,trauma 28,multiple gsw

*****Final Report*****

KUB

History: Gunshot wound

Reference:
No priors

Findings:

Streaky lucency seen over the right lower quadrant likely represent subcutaneous air. No evidence of free air on this supine film. No significant radiographic abnormalities of the bowel gas pattern or visualized soft tissues. Punctate metallic foreign bodies seen consistent with bullet fragments.

Impression:

1. Subcutaneous emphysema seen over the right lower quadrant.
2. Punctate opacities consistent with bullet fragments.

Staff addendum: No definite free air is identified, however this technique/projection is not sensitive for this purpose. A decubitus view, CT, or upright view of the chest would be more helpful to discern the streaky lucency seen projecting over the right abdomen. This could represent air within bowel gas, although this is uncertain. Subcutaneous emphysema cannot be discerned on this study.

I personally reviewed the study and the report above and concur.

Report Dictated by: Heather Gallmann Strittmatter MD, Resident
Electronically Signed by: Amy Lantis DeFatta MD

Date transcribed: 3/23/2007 20:28:26
Transcribed By: pow

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **LAMBDA, F**
MRN: **000004131790**
DOB: 1/1/1984

Patient Type: Emergency
Patient Location: ED EAST
Requesting Location: ER East
Ordering Physician: John F. Marcucci MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):
Hand, Left 2 Views ER 3/23/2007 19:57 P: 22043999
Wrist, Left 2 Views ER 3/23/2007 19:57 P: 22044014

Reason For Exam: POSS FX

*****Final Report*****

Two views of the left wrist and 2 views of the left hand without prior images for comparison demonstrate multiple metallic fragments scattered throughout the hand and distal forearm. Comminuted fracture of the distal ulnar shaft contains a large, approximately 1 cm in maximal diameter, metallic fragments. The distal fracture fragment remains in near anatomic alignment. An ulnar styloid fractures also present, of uncertain age. Also noted is a nondisplaced comminuted fracture of the distal shaft of the first metacarpal. Extension into the articular capsule is not completely evaluated on this exam. However, extension appears likely based on these images. Dedicated imaging of the thumb is recommended for further evaluation of this fracture when clinically appropriate. Diffuse swelling of the soft tissues of the hand is identified. Otherwise, no other fractures are seen.

Impression:
Innumerable bullet fragments throughout the hand and distal forearm

Large bullet fragment lodged within the distal ulnar shaft results in a minimally displaced comminuted fracture

Nondisplaced fracture of the distal first metacarpal. Extension into the joint capsule is very likely though not completely evaluated on this exam

I personally reviewed the study and the report above and concur.

Report Dictated by: Ethan Oren Cohen MD, Resident
Electronically Signed by: Amy Lantis DeFatta MD

Date transcribed: 3/23/2007 23:18:29
Transcribed By: pow

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **LAMBDA, F**
MRN: **000004131790**
DOB: 1/1/1984

Patient Type: Emergency
Patient Location: ED EAST
Requesting Location: ER East
Ordering Physician: Stacy L. Lee MD
Attending Physician: Fernando L. Benitez MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):
Pelvis ER

3/23/2007 19:53 P: 22043951

Reason For Exam: ,east trauma 28,multiple gsw

*****Final Report*****

AP Pelvis

Clinical indications:
Trauma

Technique:
AP supine view of the pelvis was obtained.

Findings:
No significant radiographic abnormalities are seen of the pelvic ring, visualized portions of the lower lumbar spine and proximal femurs, joint spaces and visualized soft tissues. Scattered punctate opacities consistent with bullet fragments.

Impression: No significant radiographic abnormalities of the pelvis seen.

I personally reviewed the study and the report above and concur.

Report Dictated by: Heather Gallmann Strittmatter MD, Resident
Electronically Signed by: Amy Lantis DeFatta MD

Date transcribed: 3/23/2007 20:30:26
Transcribed By: pow

620

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **LAMBDA, F**
MRN: **000004131790**
DOB: 1/1/1984

Patient Type: Emergency
Patient Location: ED EAST
Requesting Location: ER East
Ordering Physician: John F. Marcucci MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):
Knee, Right 2 Views ER

3/23/2007 19:57 P: 22044002

Reason For Exam: POSS FX

*****Final Report*****

Exam: 2 views of the right knee obtained on 3/23/2007. There are no prior films available for comparison.

Findings: Calcific density is seen in the posterior medial aspect of the knee just superior to the medial femoral condyle. This may represent foreign body. Clinical correlation is recommended. No fractures or dislocations are seen. No joint effusions are identified.

Impression:
Foreign body in the posterior medial aspect of the knee as described above. Clinical correlation is recommended. No fractures or dislocations are identified.

Staff addendum: Irregular calcification is noted along the posterior medial aspect of the knee. This finding may represent sequela from prior trauma. No subcutaneous emphysema is identified to suggest that this represents an acute foreign body. The calcification is not associated with the femur. It does not appear vascular in origin. A CT could be of further benefit, as clinically warranted.

I personally reviewed the study and the report above and concur.

Report Dictated by: Brian Paul Giles MD, Resident
Electronically Signed by: Amy Lantis DeFatta MD

Date transcribed: 3/23/2007 23:31:31
Transcribed By: pow

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **LAMBDA, F**
MRN: **000004131790**
DOB: 1/1/1984

Patient Type: Emergency
Patient Location: ED EAST
Requesting Location: ER East
Ordering Physician: Shahid Shafi MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):

Wrist, Right 2 Views ER	3/23/2007 19:57	P: 22044016
Humerus, 2 Views, Right OR	3/23/2007 19:57	P: 22043960
Forearm, Right ER	3/23/2007 19:57	P: 22044017

Reason For Exam: A-GRAM

*****Final Report*****

Two views of the right wrist, 2 views of the right forearm, and 2 views of the right humerus demonstrate innumerable small metallic fragments throughout the dorsal soft tissues of the forearm, deep soft tissues of the distal forearm, anterior and dorsal soft tissues of the upper arm, soft tissues within the axilla, and lateral soft tissues of the shoulder. Subcutaneous emphysema is associated with all these fragments. Many of these fragments likely estimated to down to bone. Comminuted fracture of the distal ulnar shaft with relatively maintained alignment of the largest distal fracture fragment. As well, metallic fragments intermixed with bone fragments are indicative of bullet track through the distal ulnar bone.

Impression:
Innumerable bullet fragments, as described above

Distal ulnar fracture, as noted above

I personally reviewed the study and the report above and concur.

Report Dictated by: Ethan Oren Cohen MD, Resident
Electronically Signed by: Amy Lantis DeFatta MD

Date transcribed: 3/23/2007 23:06:28
Transcribed By: pow

620

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **LAMBDA, F**
MRN: **000004131790**
DOB: 1/1/1984

Patient Type: Emergency
Patient Location: ED EAST
Requesting Location: ER East
Ordering Physician: Stacy L. Lee MD
Attending Physician: Fernando L. Benitez MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):
Chest, Single View ER 3/23/2007 19:53 P: 22043950

Reason For Exam: ,east trauma 28,multiple gsw

*****Final Report*****

Single portable view of the chest

Findings:

Cardiomediastinal structures are unremarkable. The lungs are clear. No pneumothorax is seen. No acute fractures are seen. Multiple metallic bullet fragments seen over right chest wall tissues, left shoulder, and left lower lung.

Impression:

Multiple bullet fragments noted without evidence of acute thoracic trauma.

I personally reviewed the study and the report above and concur.

Report Dictated by: Heather Gallmann Strittmatter MD, Resident
Electronically Signed by: Amy Lantis DeFatta MD

Date transcribed: 3/23/2007 20:24:23
Transcribed By: pow

Parkland Health & Hospital System

Department of Radiology
UT Southwestern Radiologists

Pt. Name: **LAMBDA, F**
MRN: **000004131790**
DOB: 1/1/1984

Patient Type: Inpatient
Patient Location: SICU-Room 200d
Requesting Location: 2N SICU D
Ordering Physician: Daniel Joseph Hayes MD
Attending Physician: Shahid Shafi MD
Admitting Physician: Gary F. Purdue MD

ICD-9:

Exam(s):
Chest-1 View DX 3/24/2007 18:34 P: 22044617

Reason For Exam: ,eval chest tubes

*****Final Report*****

Portable film dated 3/24 at 2311 hours compared with film obtained about 5 hours prior. Bilateral chest tubes remain, no evidence of pneumothorax. Note is taken that the right paratracheal area area which appeared somewhat prominent on the previous film now appears quite normal. Actually, some of this abnormality related to patient positioning and rotation. No new infiltrate. Evidence of prior gunshot wound.

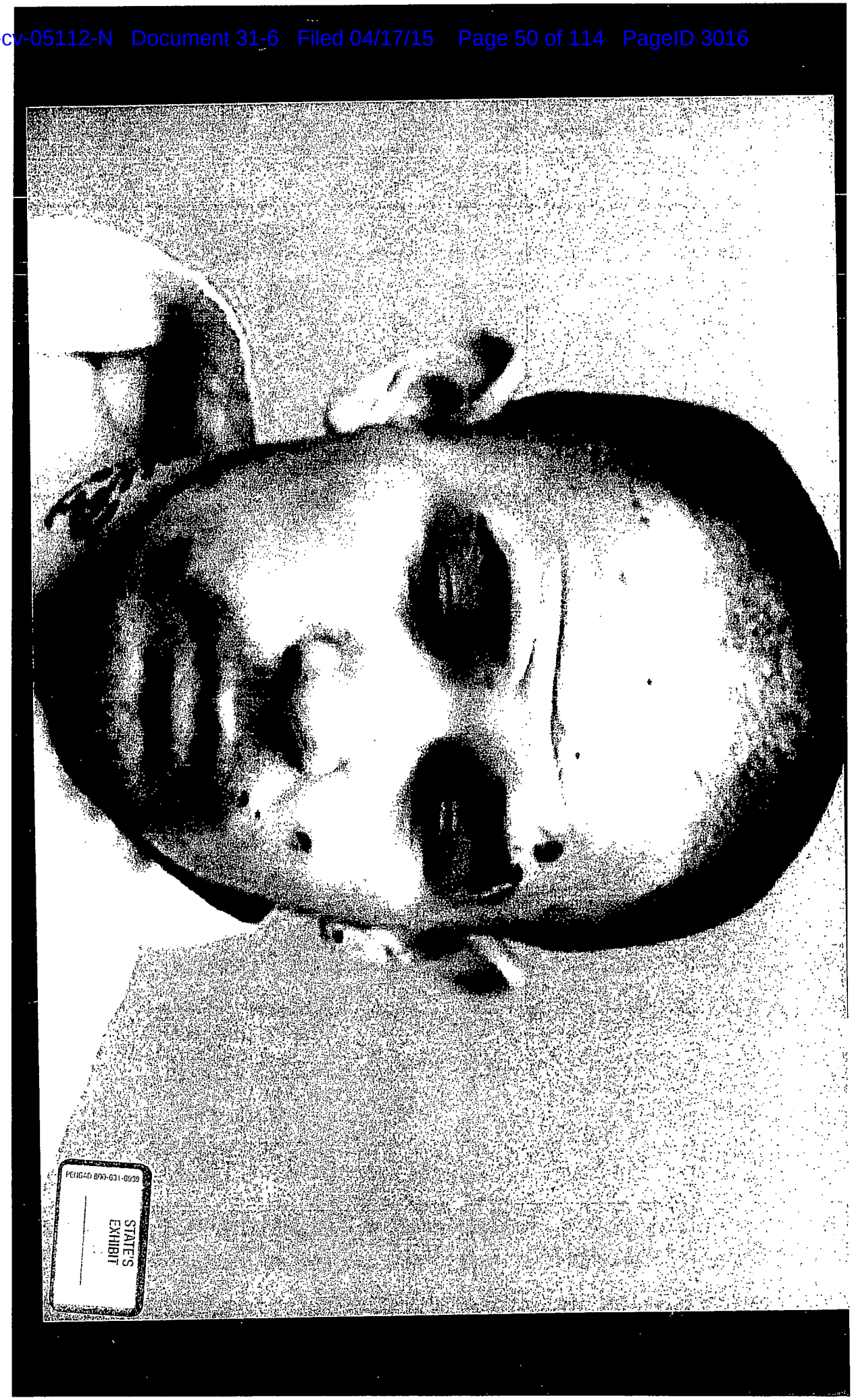
Impression: Allowing for technique, no significant change.

Electronically Signed by: George C. Curry MD

Date transcribed: 3/25/2007 09:20:20
Transcribed By: pow

STATE'S EXHIBIT NO. 32-A

PHOTOGRAPH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STATE'S EXHIBIT NO. 33

PHOTOGRAPH

STATE'S
EXHIBIT
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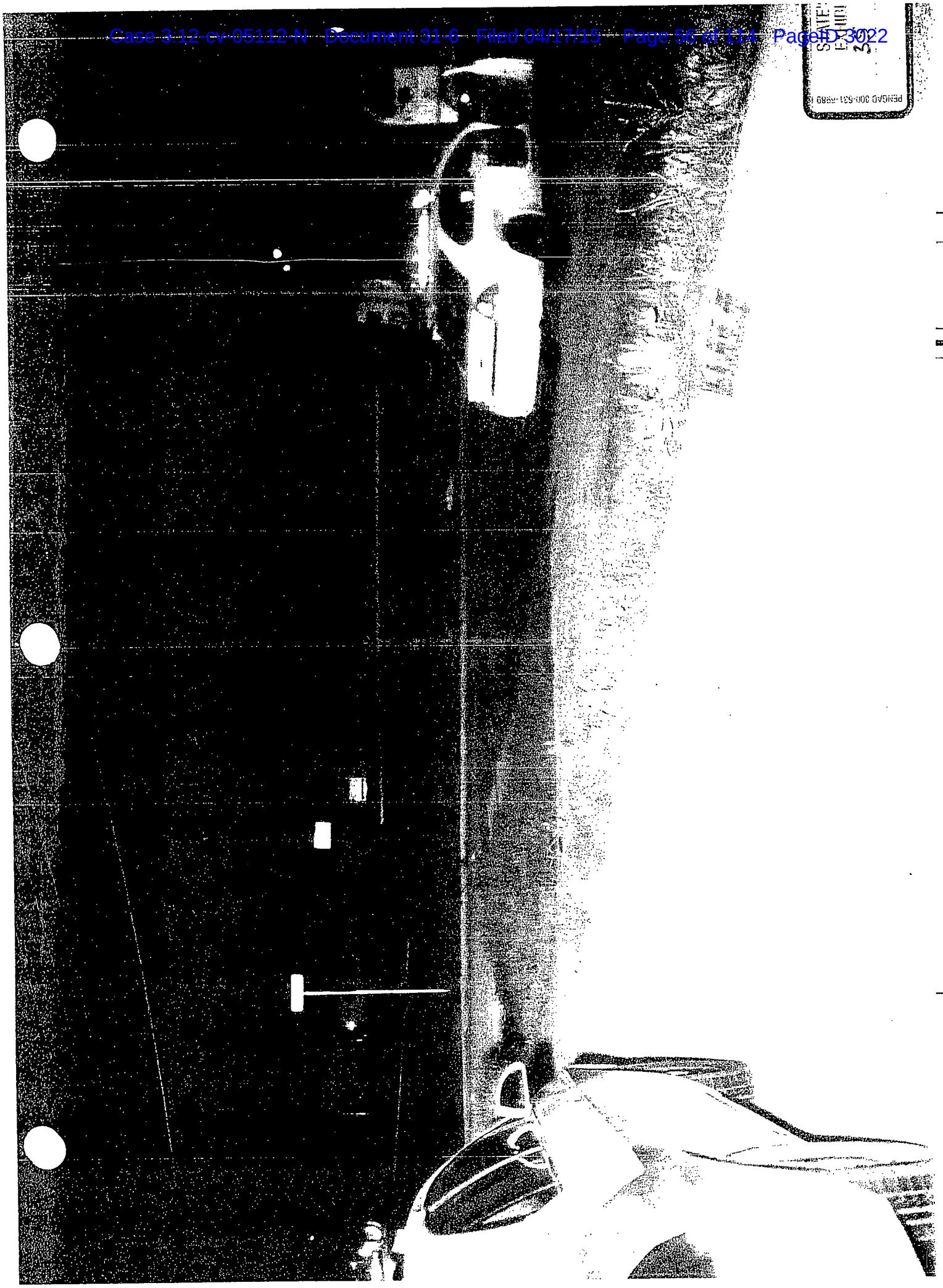
STATE'S EXHIBIT NO. 34

PHOTOGRAPH

STATE'S EXHIBIT 34

STATE'S EXHIBIT NO. 35

PHOTOGRAPH



STATE'S EXHIBIT NO. 36

PHOTOGRAPH

STATE'S EXHIBIT 30

PENGAD 800-631-6989

POLICE LINE DO NOT CROSS

POLICE LINE DO NOT CROSS

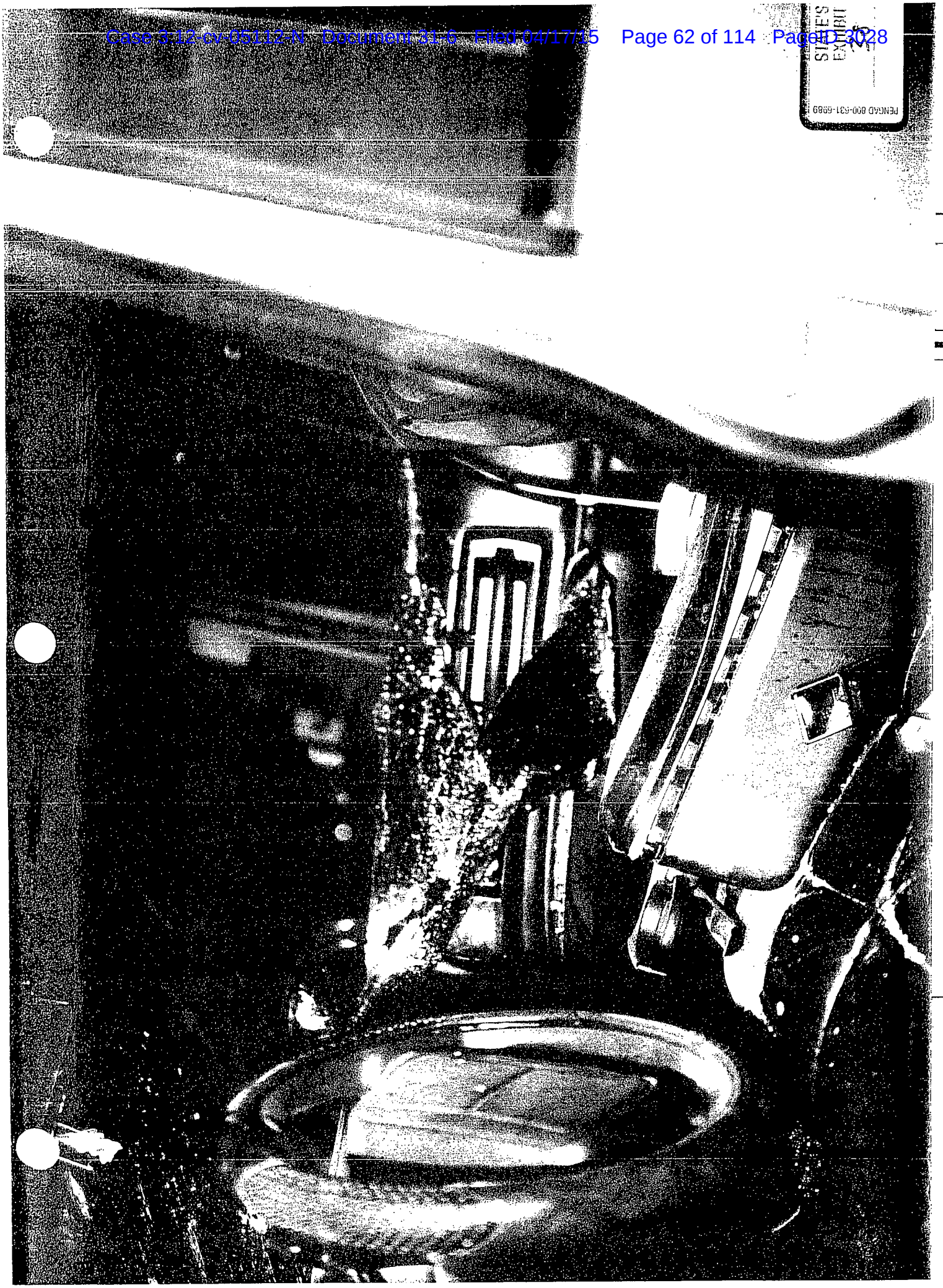
STATE'S EXHIBIT NO. 37

PHOTOGRAPH

STATE'S
EXHIBIT
3
PENGAD 800-631-6989

STATE'S EXHIBIT NO. 38

PHOTOGRAPH



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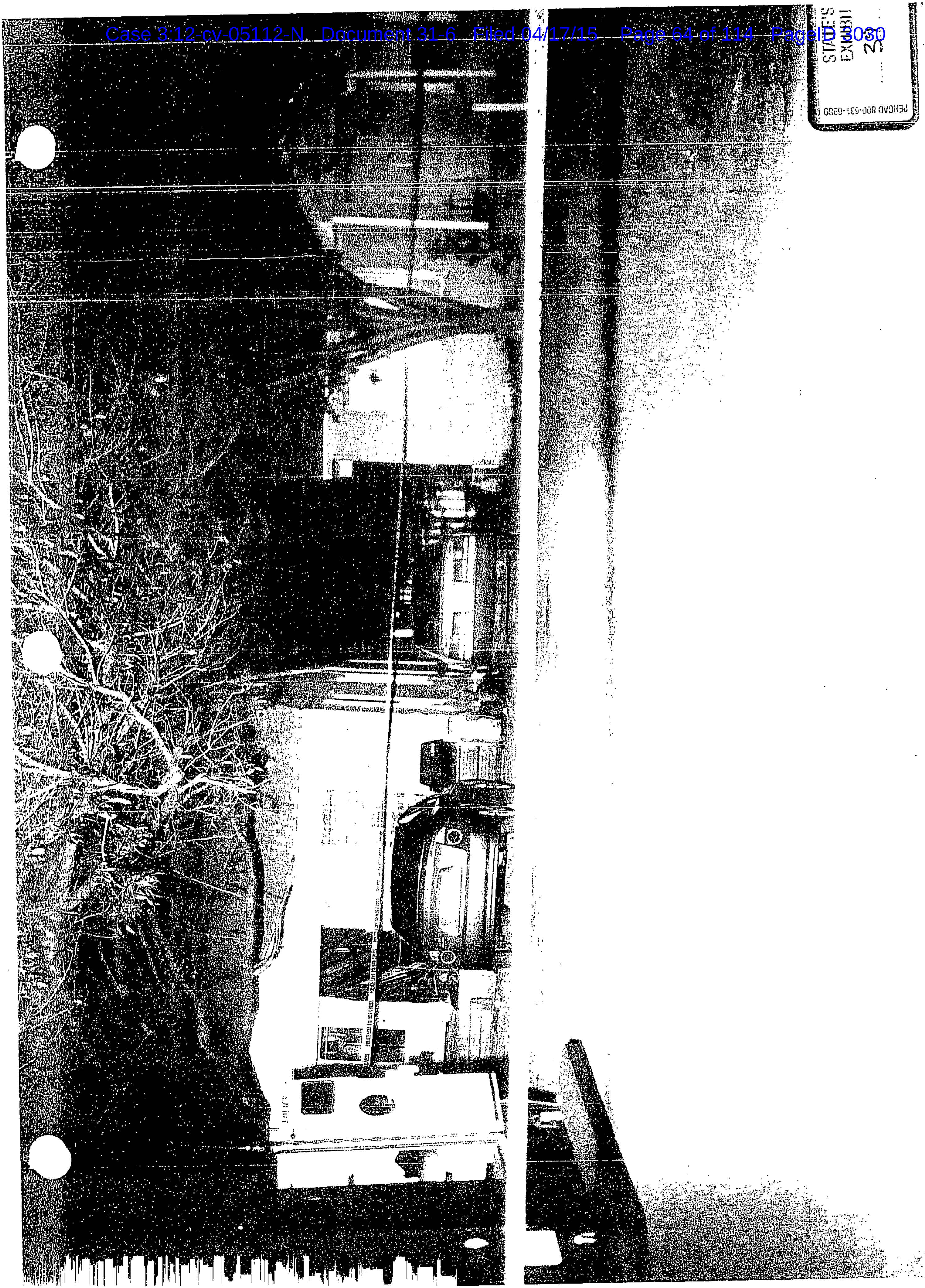


STATE'S EXHIBIT NO. 40

PHOTOGRAPH


PENGAD 800-631-6989
STATE'S EXHIBIT
40
Little Pony

STATE'S EXHIBIT NO. 41

PHOTOGRAPH

STATE'S
EXHIBIT
PENDAS 800-631-6989

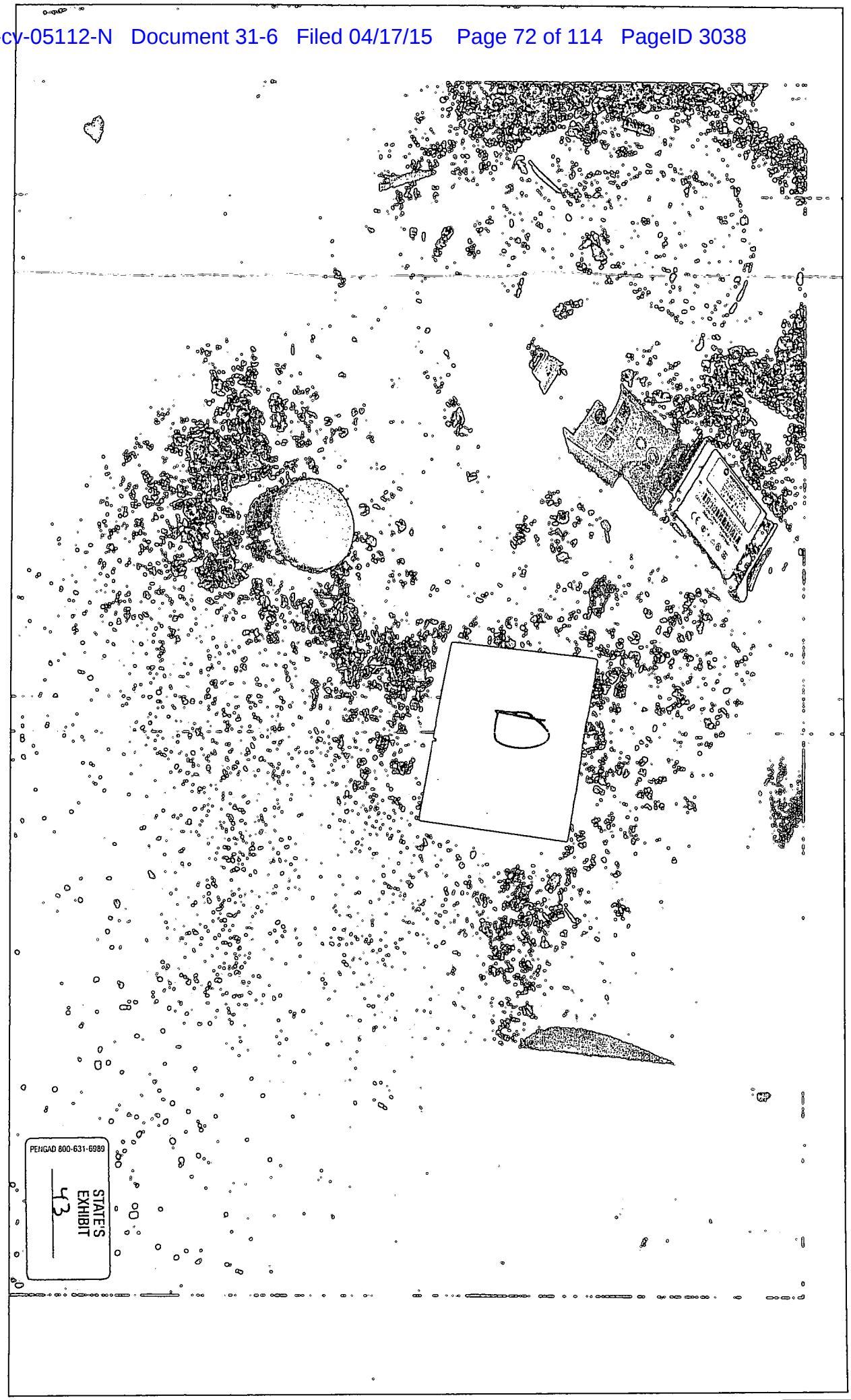
STATE'S EXHIBIT NO. 42

PHOTOGRAPH

PENGAD 800-631-6989
STATE'S EXHIBIT
12

STATE'S EXHIBIT NO. 43

PHOTOGRAPH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STATE'S EXHIBIT NO. 44

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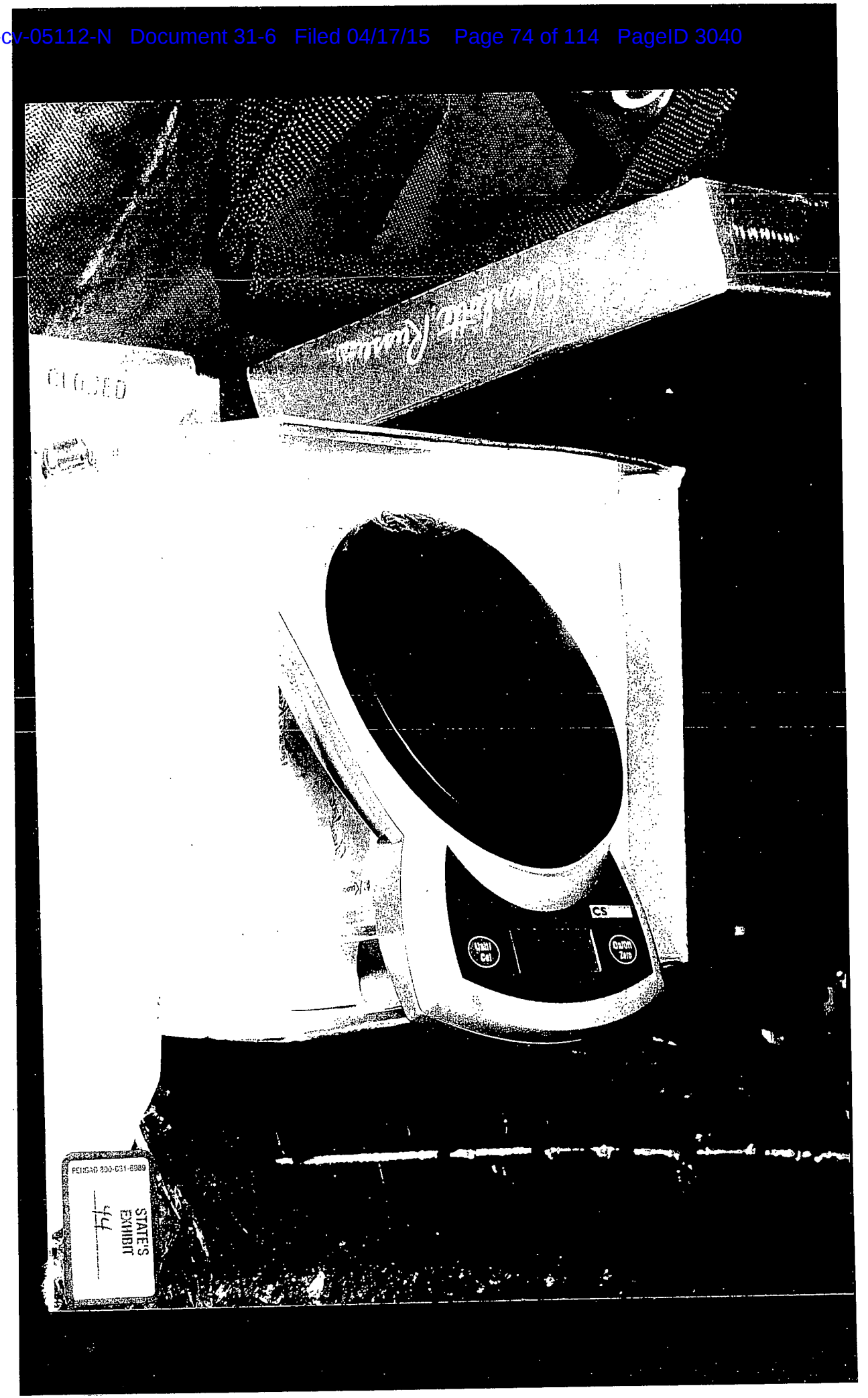
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44

STATE'S EXHIBIT NO. 45

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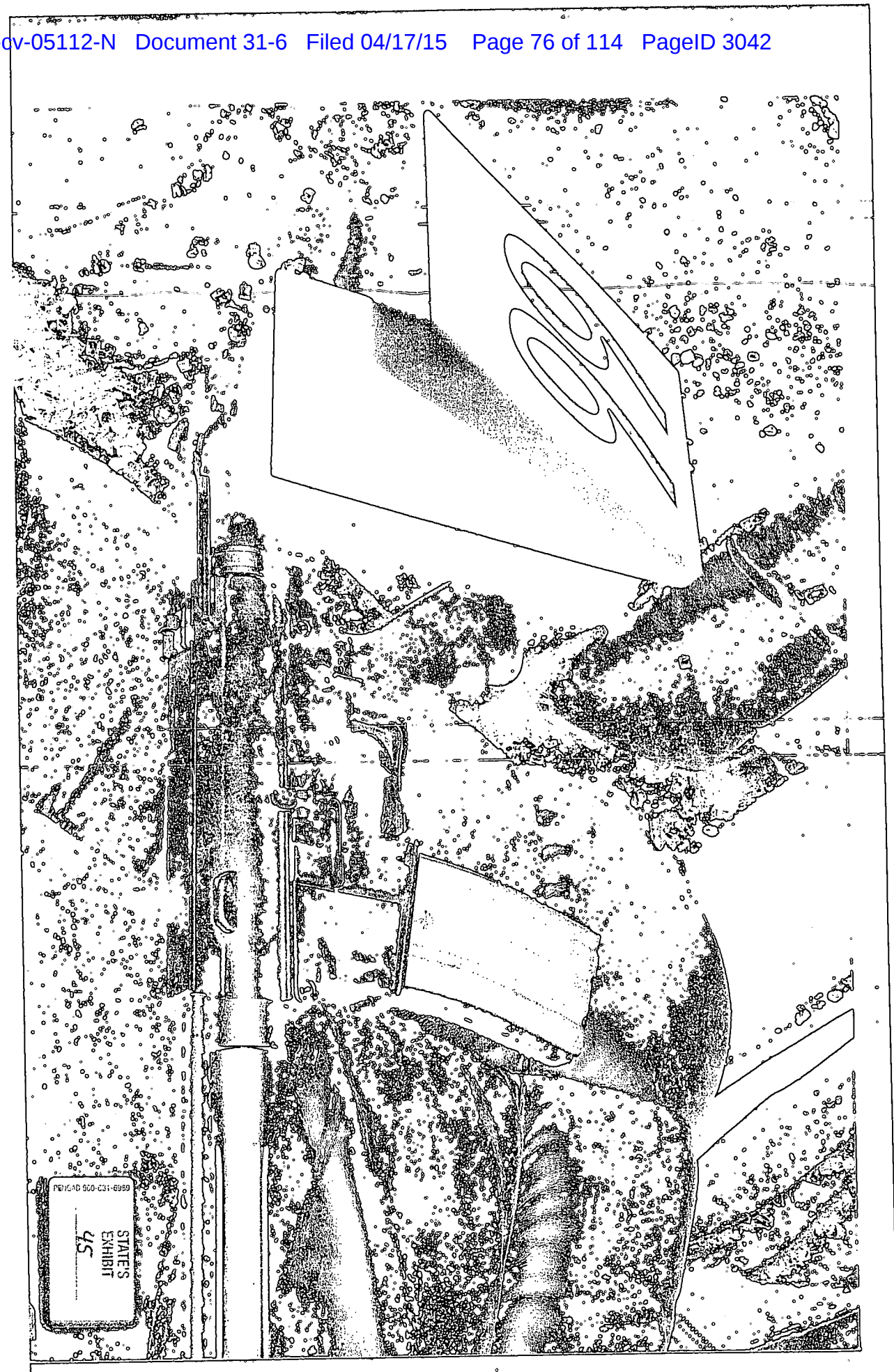
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STATE'S EXHIBIT NO. 46

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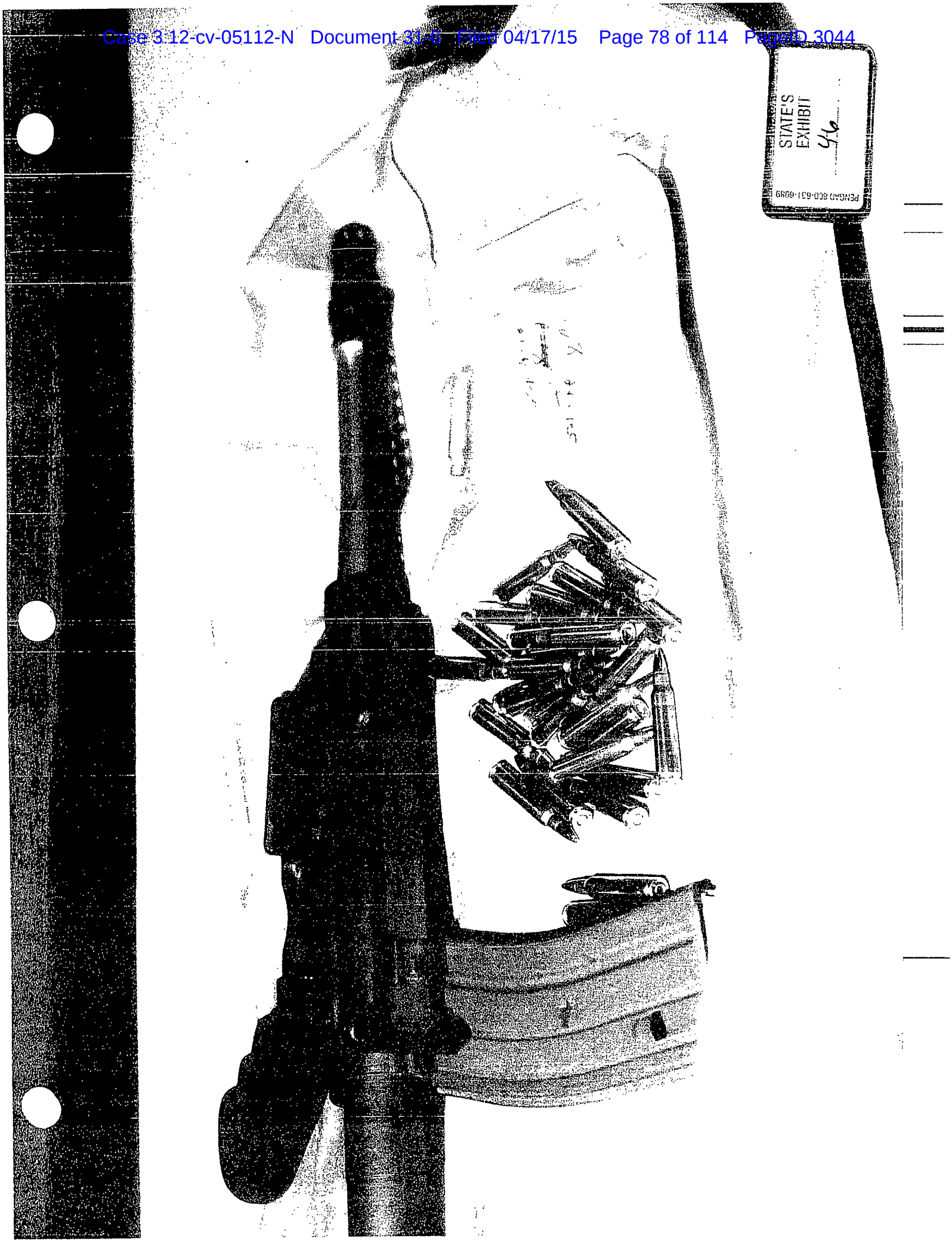
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46
PENGAD 800-631-6989

STATE'S EXHIBIT NO. 47

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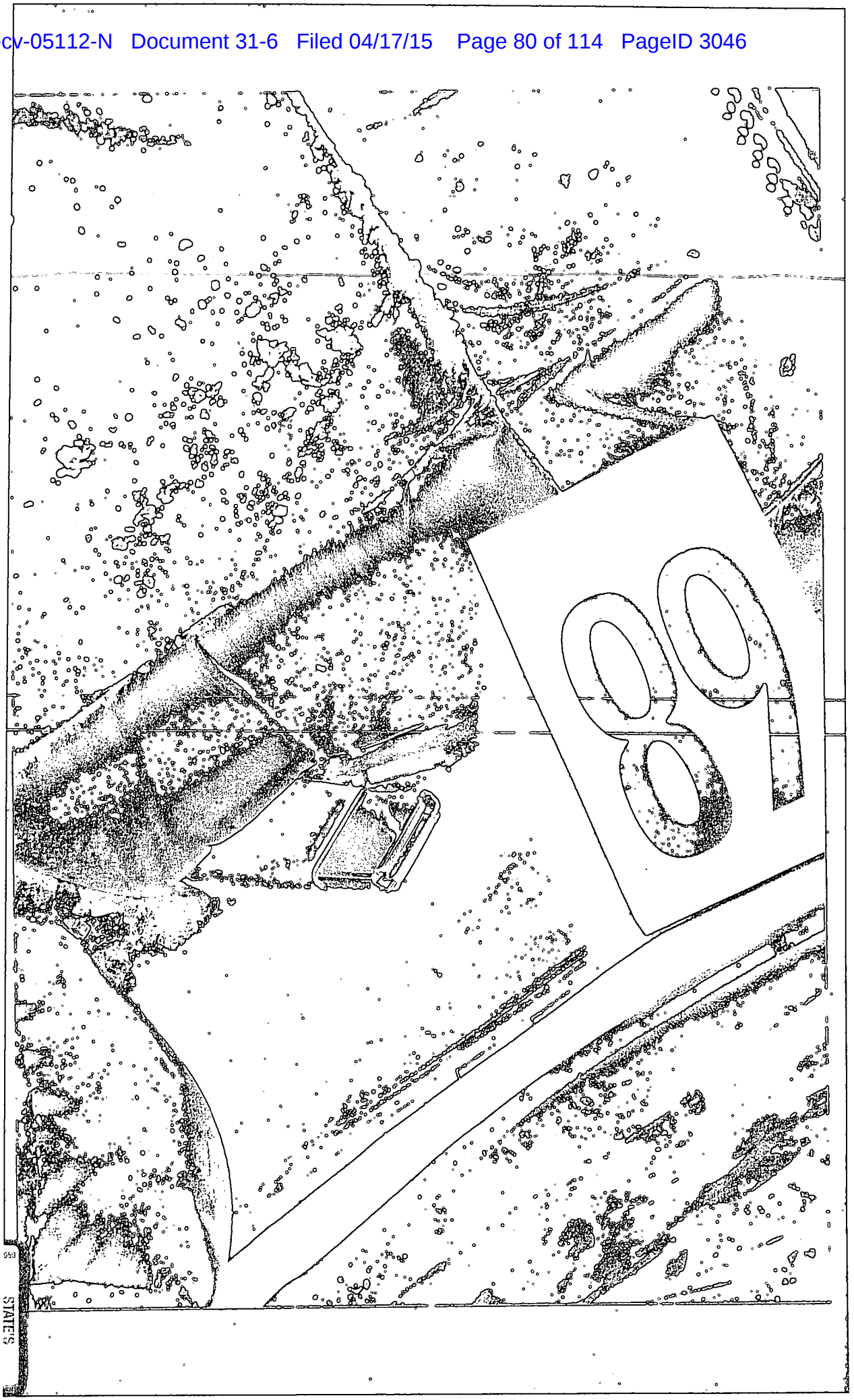
89
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STATE'S EXHIBIT NO. 48

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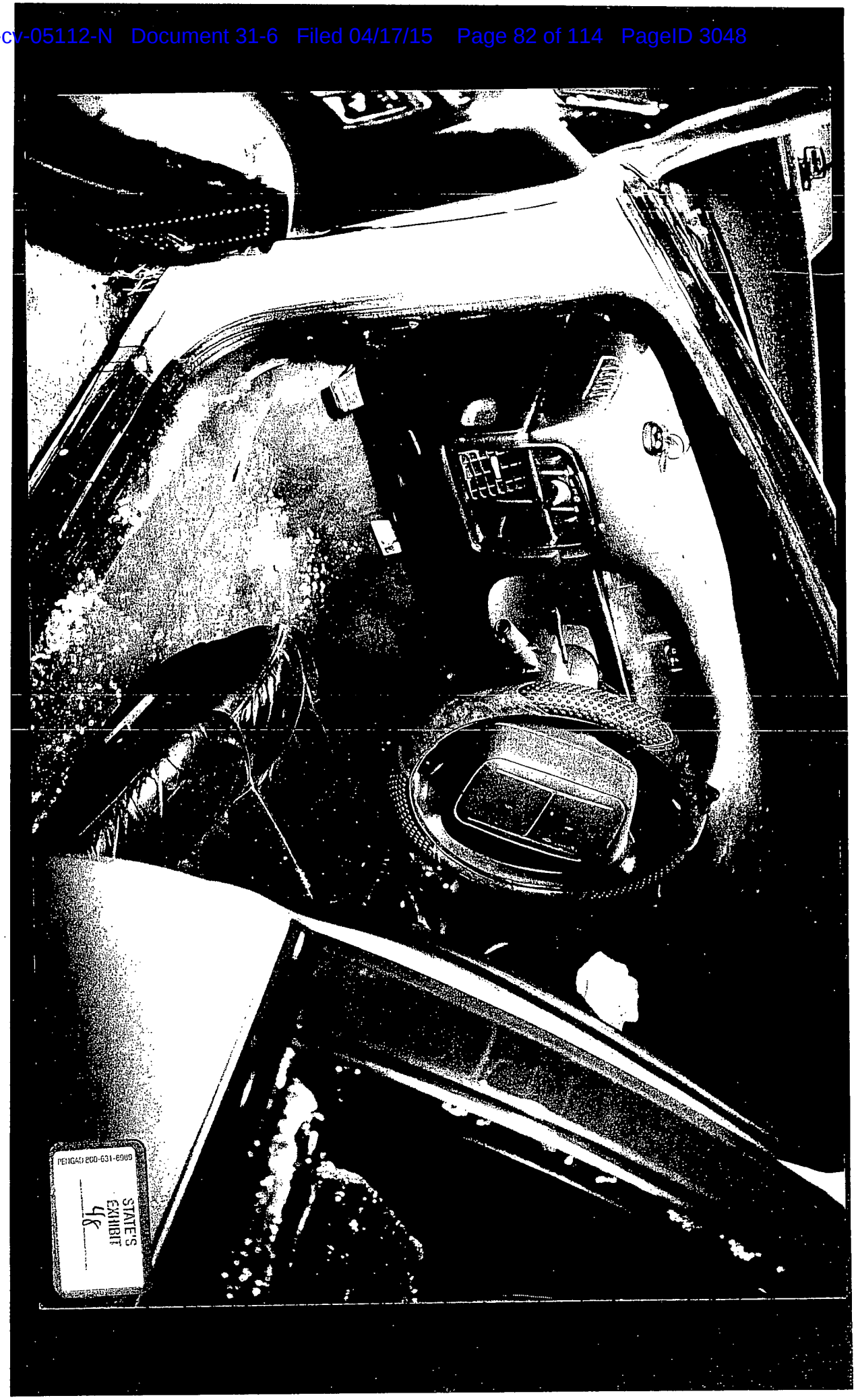
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48

STATE'S EXHIBIT NO. 49

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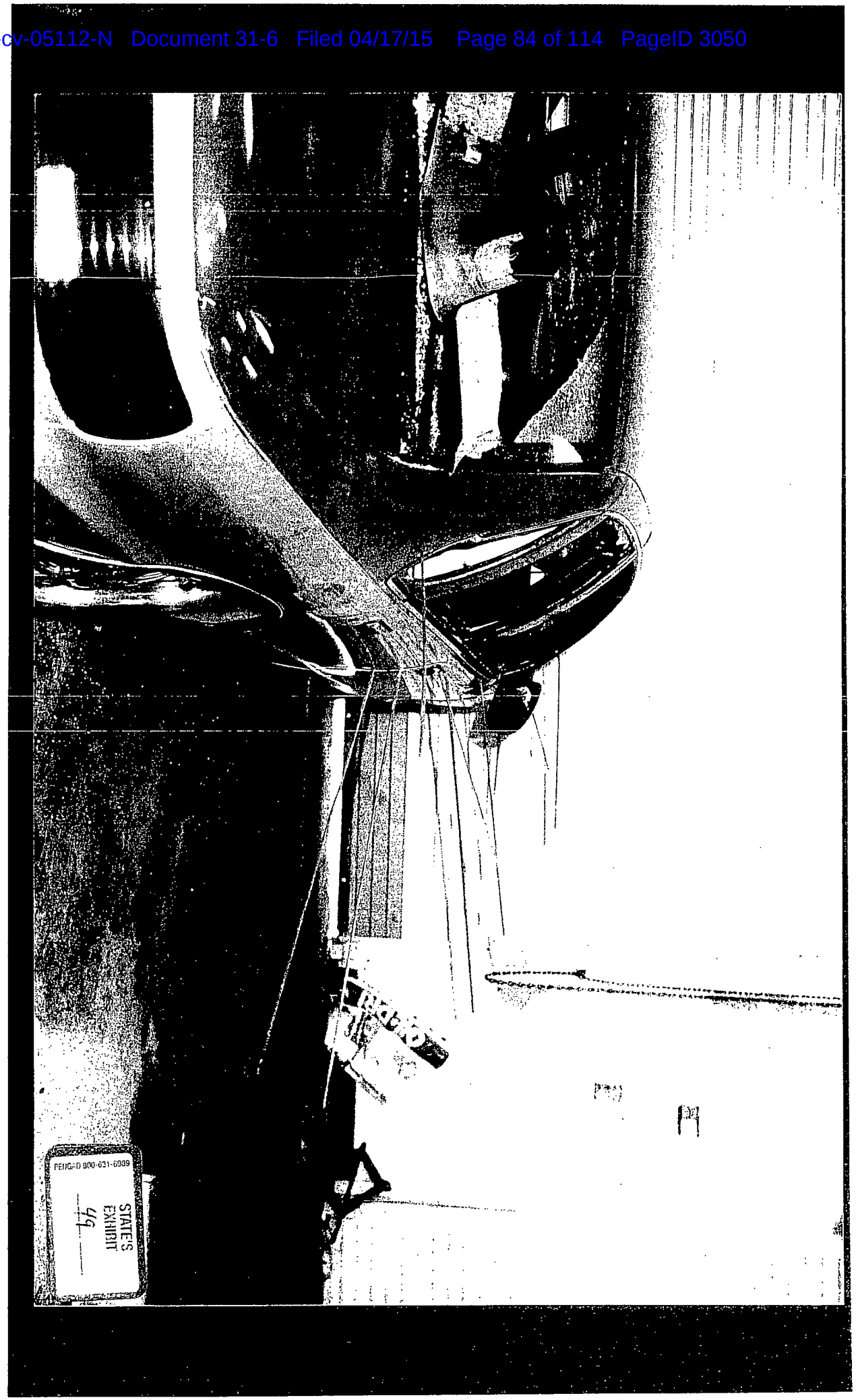
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46

STATE'S EXHIBIT NO. 50

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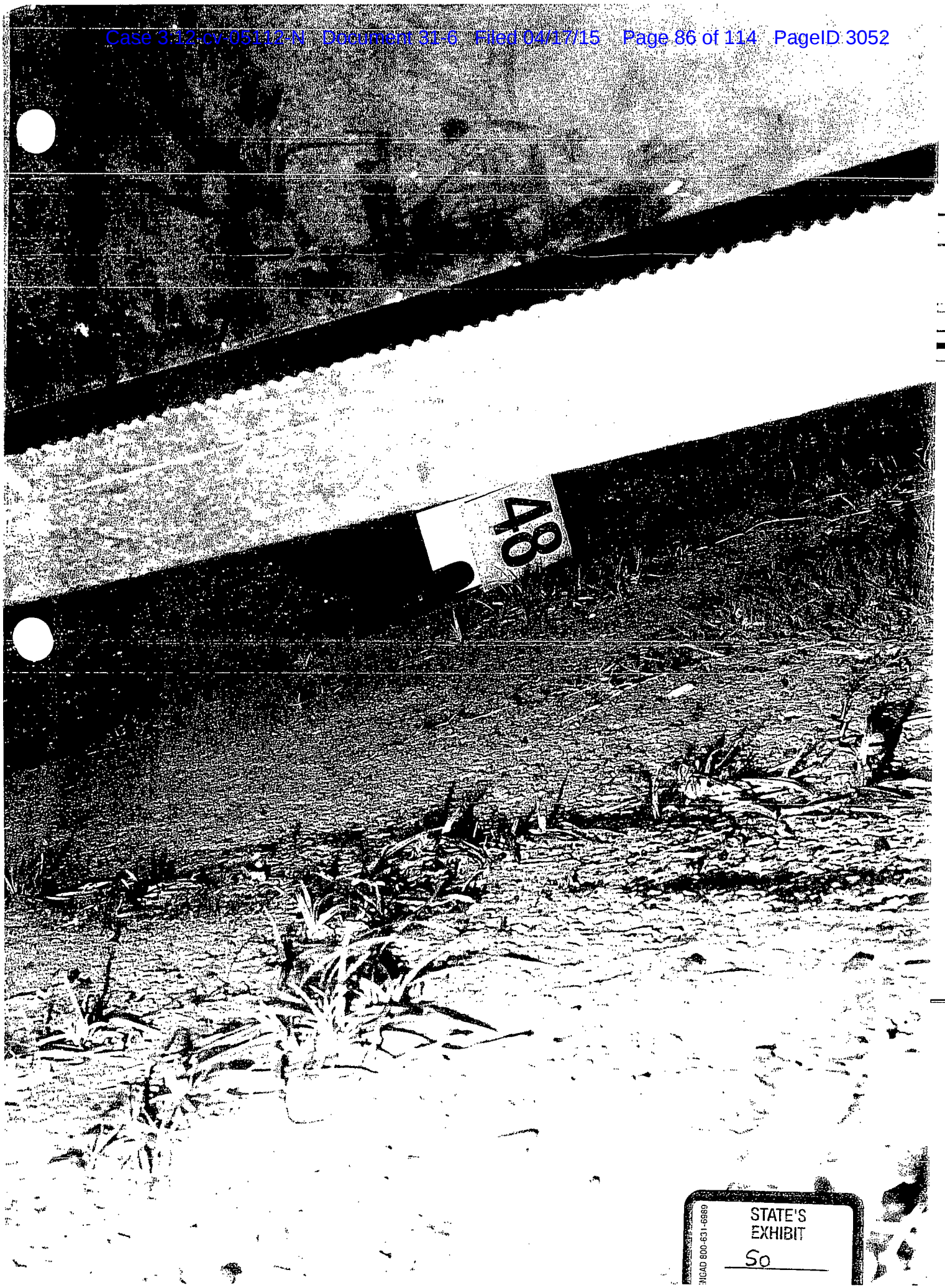


STATE'S EXHIBIT
So

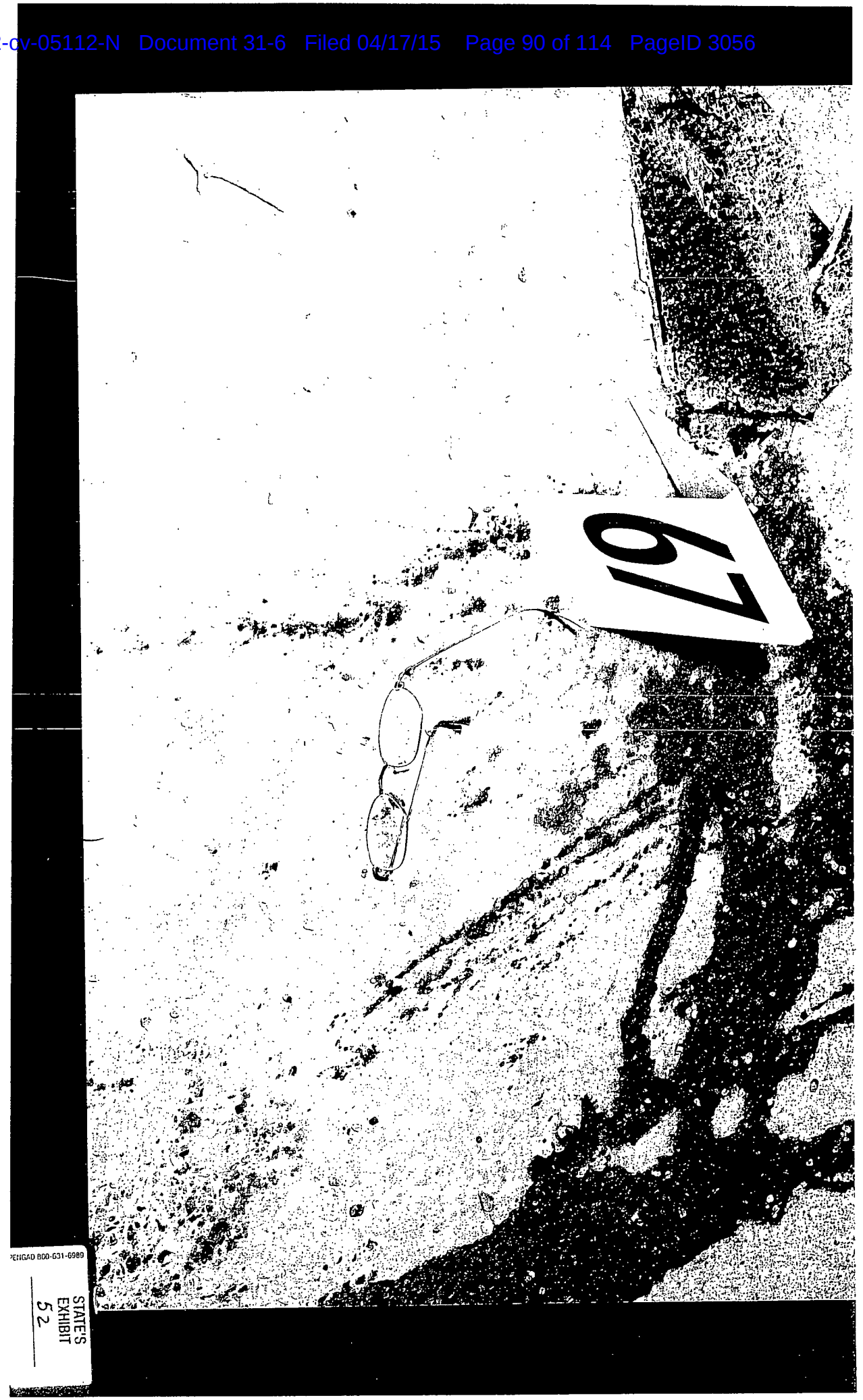
STATE'S EXHIBIT NO. 51

PHOTOGRAPH


109
STATE'S EXHIBIT

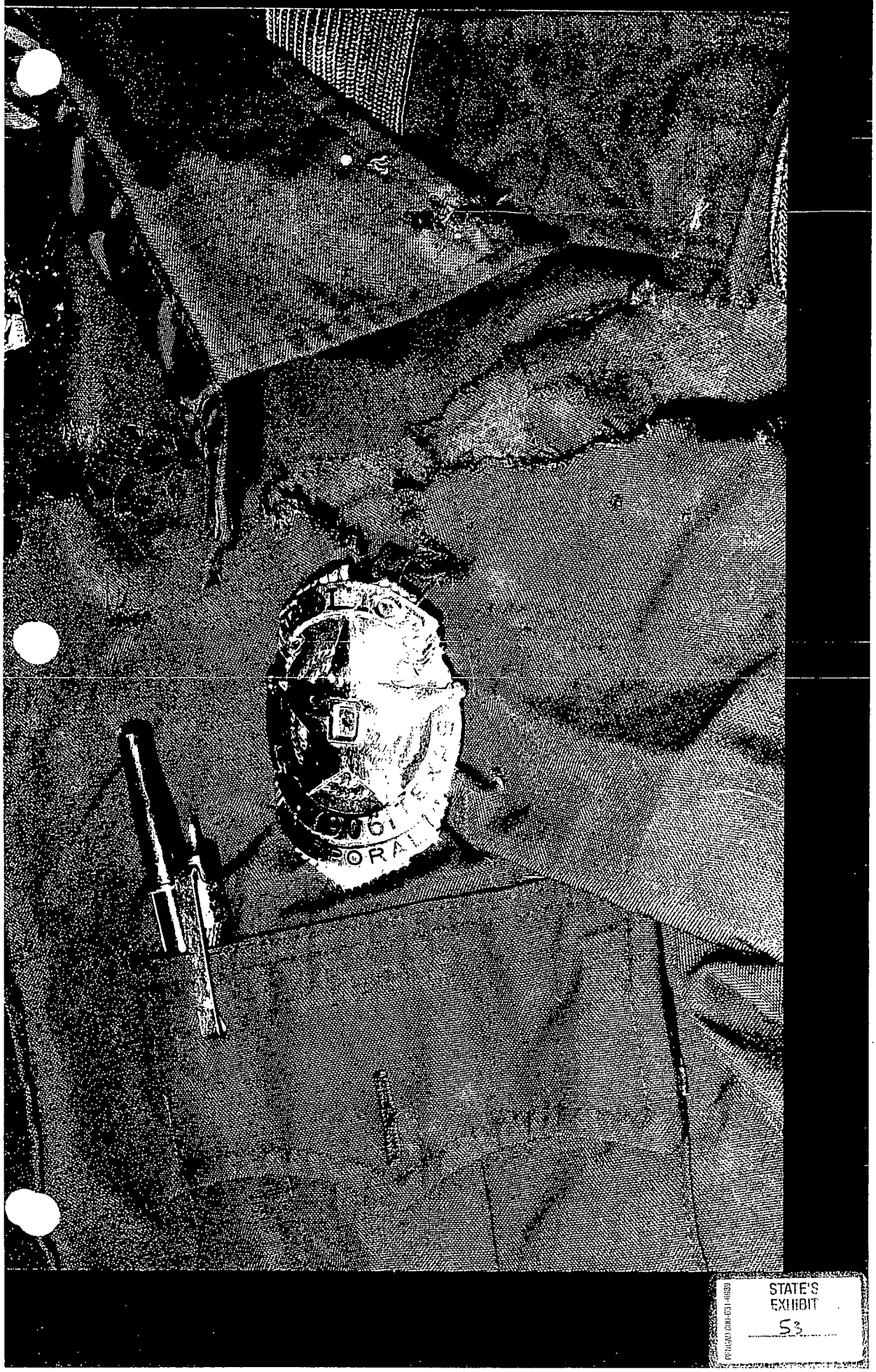
STATE'S EXHIBIT NO. 52

PHOTOGRAPH


67
PENGAD 800-631-6989
STATE'S EXHIBIT
52

STATE'S EXHIBIT NO. 53

PHOTOGRAPH



STATE'S EXHIBIT 53

STATE'S EXHIBIT NO. 54

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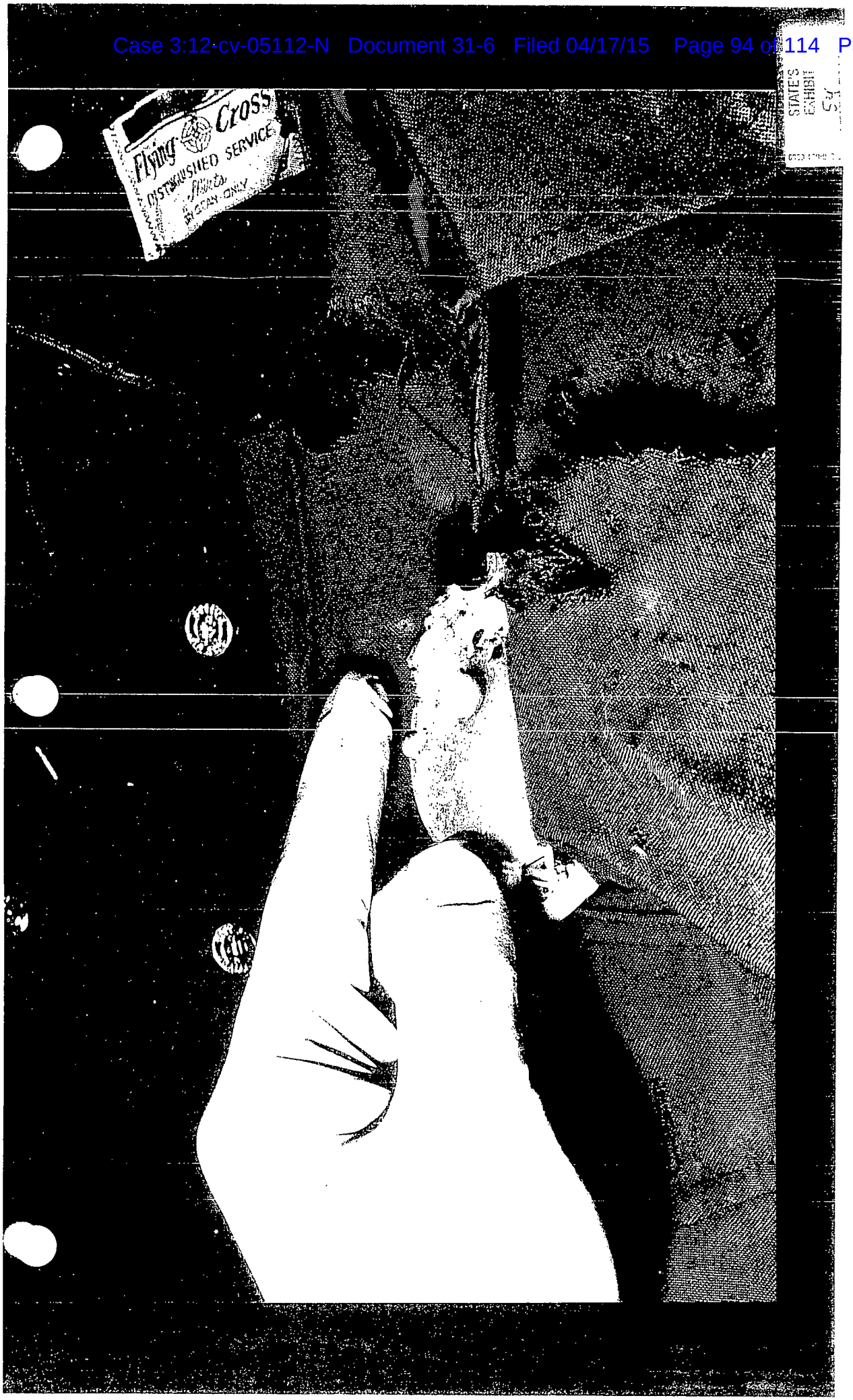
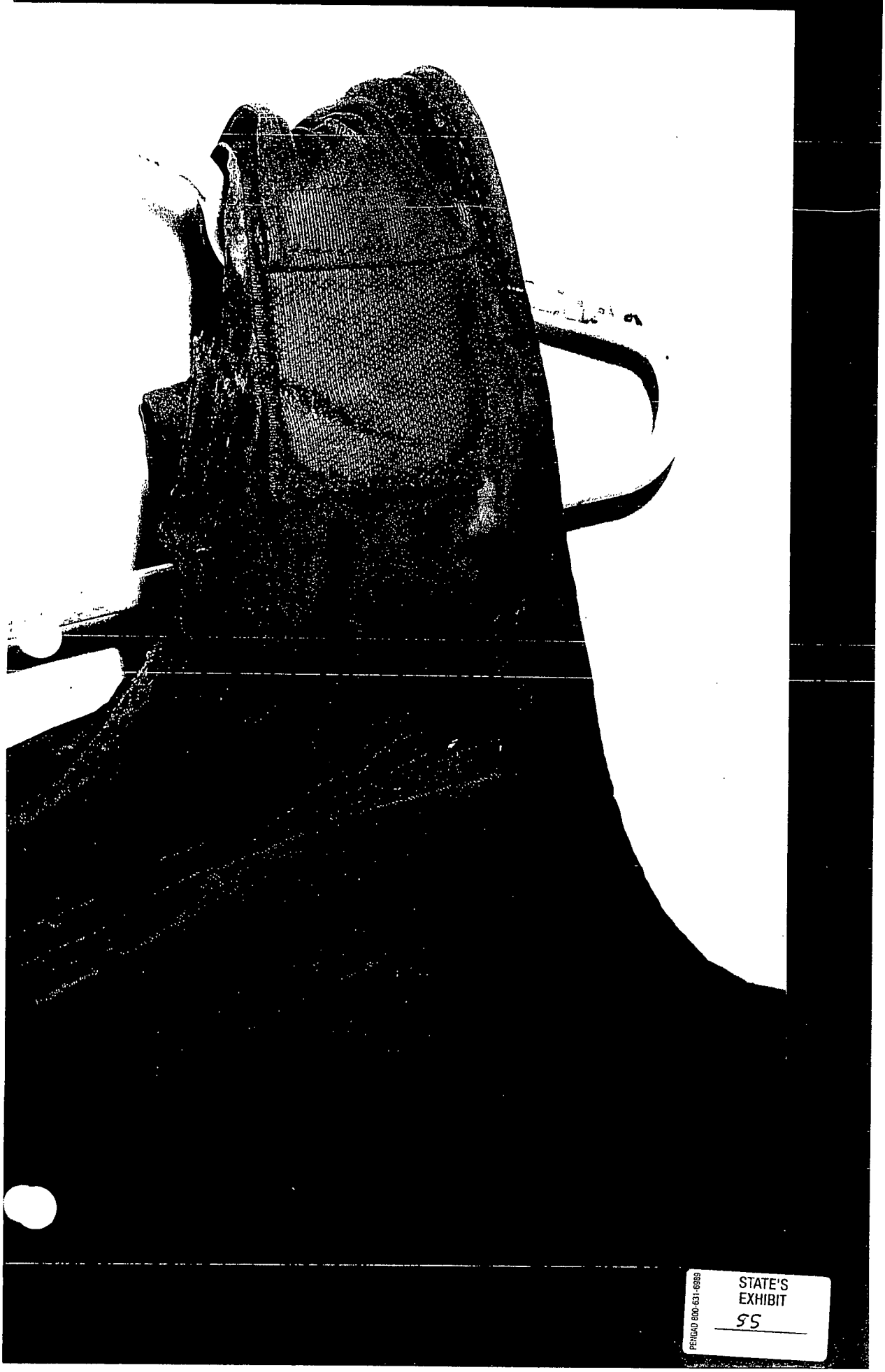

Flying Cross
DISTINGUISHED SERVICE
STATE'S EXHIBIT

STATE'S EXHIBIT NO. 55

PHOTOGRAPH



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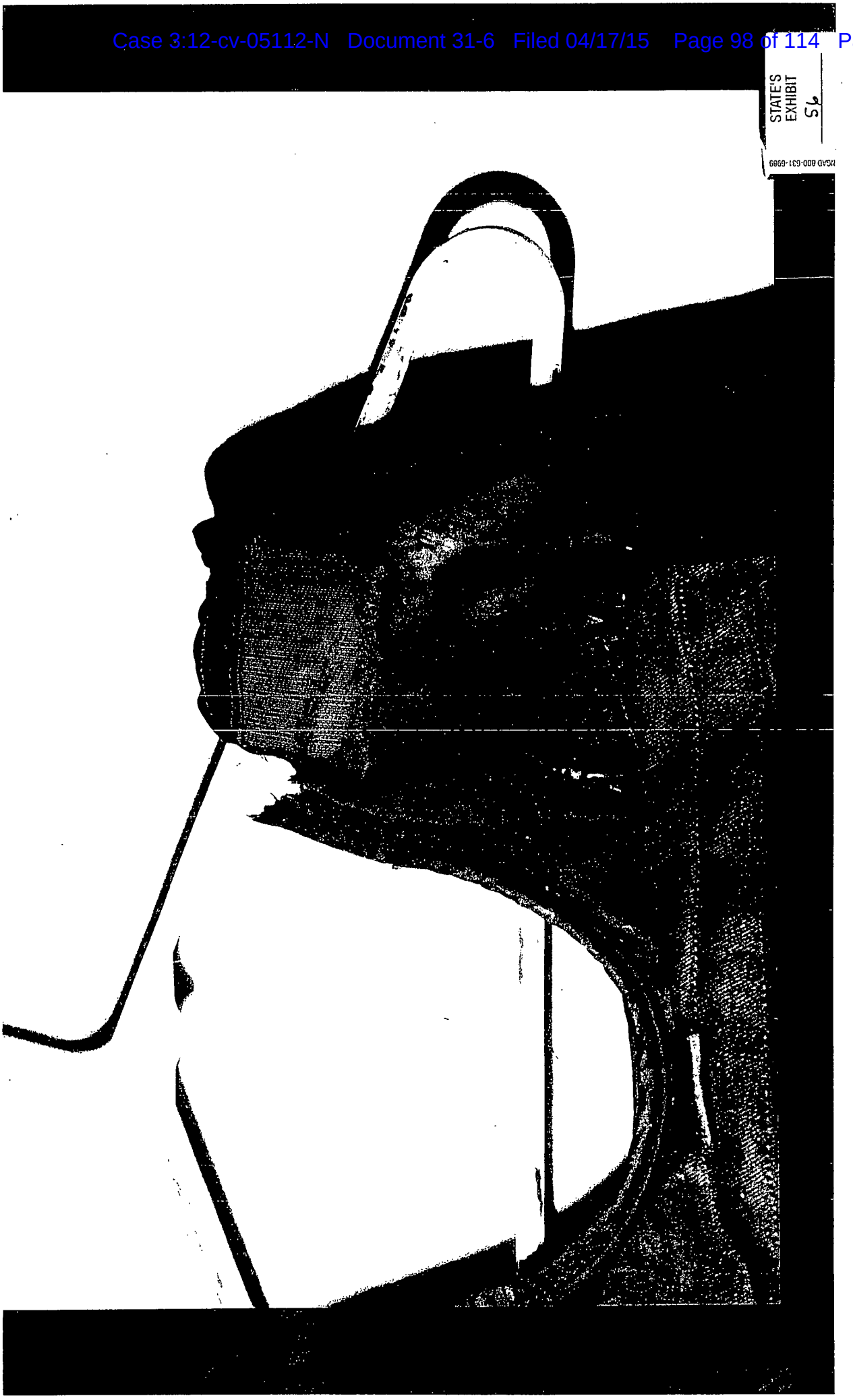
STATE'S
EXHIBIT
95
MSAD 800-631-6989

STATE'S EXHIBIT NO. 57

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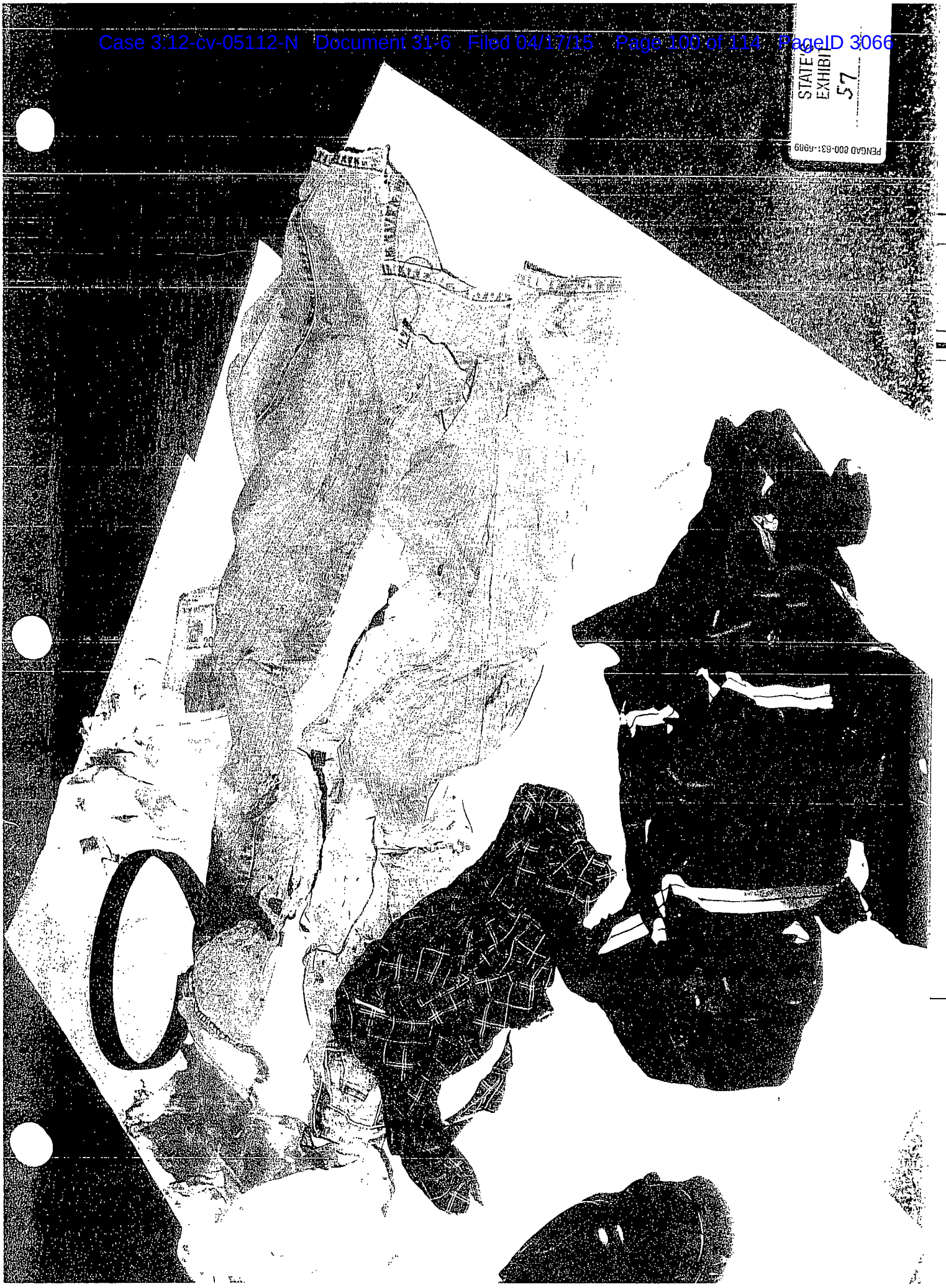

STATE'S EXHIBIT NO. 58

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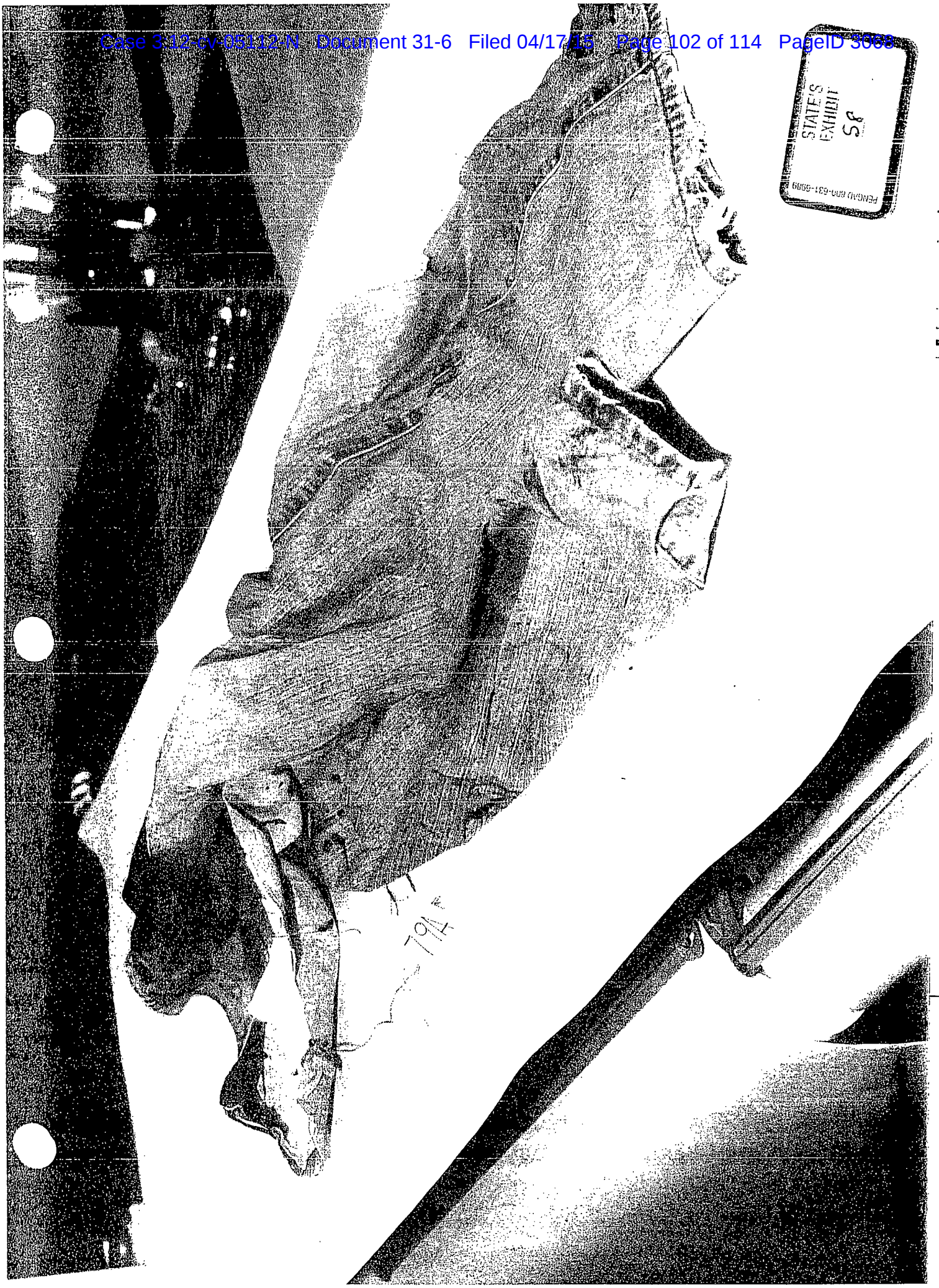

STATE'S EXHIBIT NO. 59

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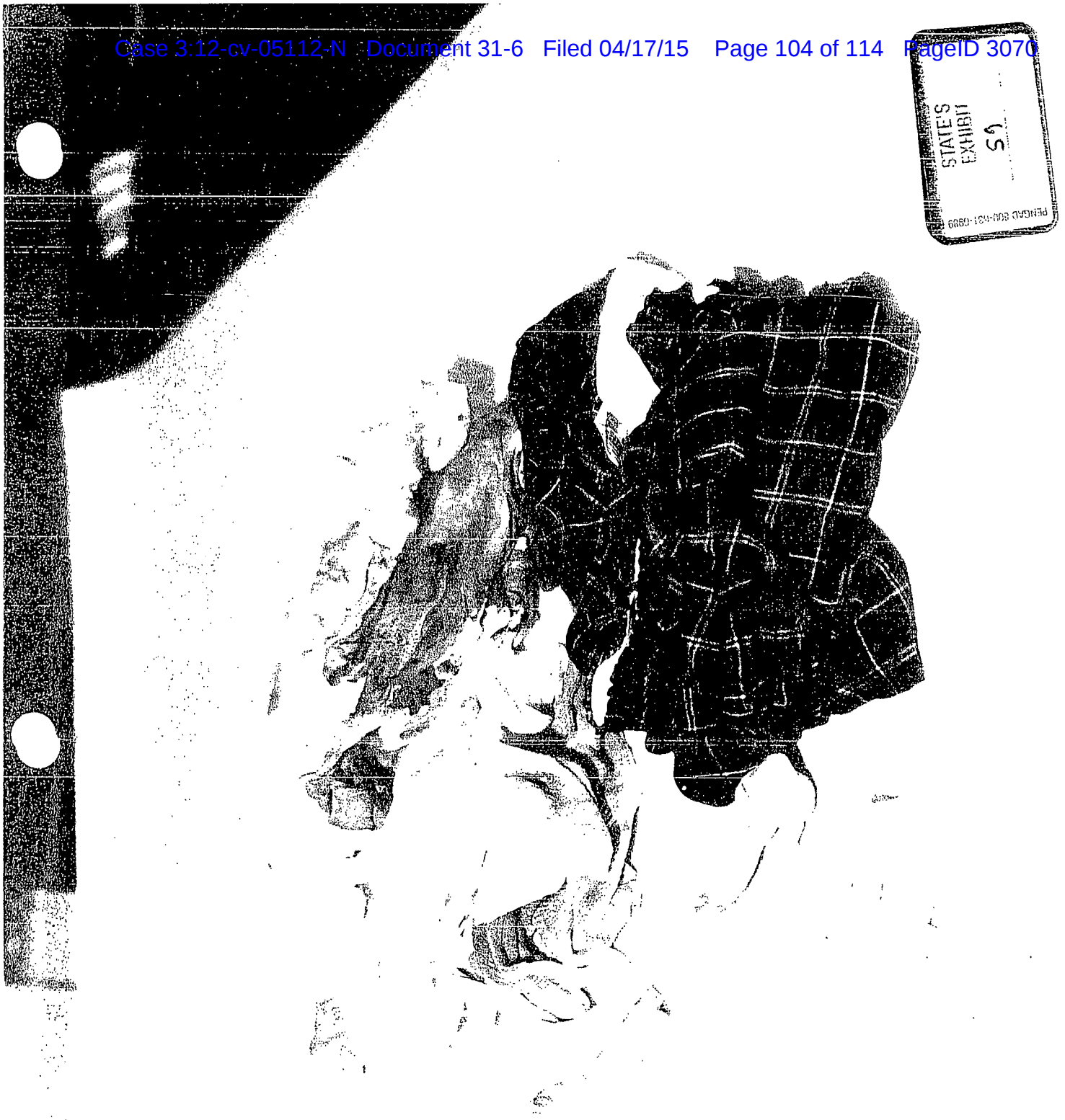
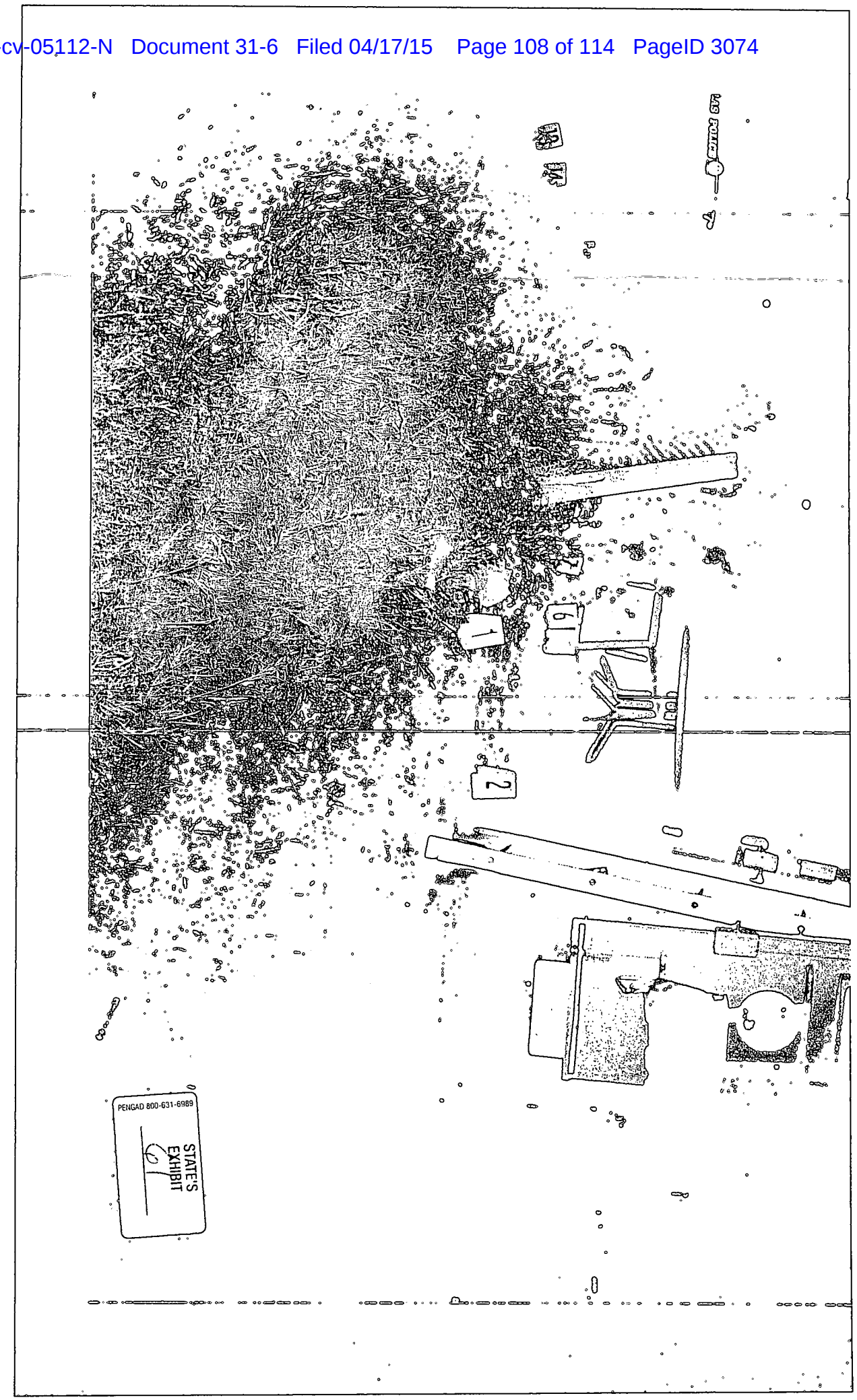


STATE'S EXHIBIT NO. 60

PHOTOGRAPH

STATE'S EXHIBIT NO. 61

PHOTOGRAPH


1
2
PENGAD 800-631-6989
STATE'S EXHIBIT
21

STATE'S EXHIBIT NO. 62

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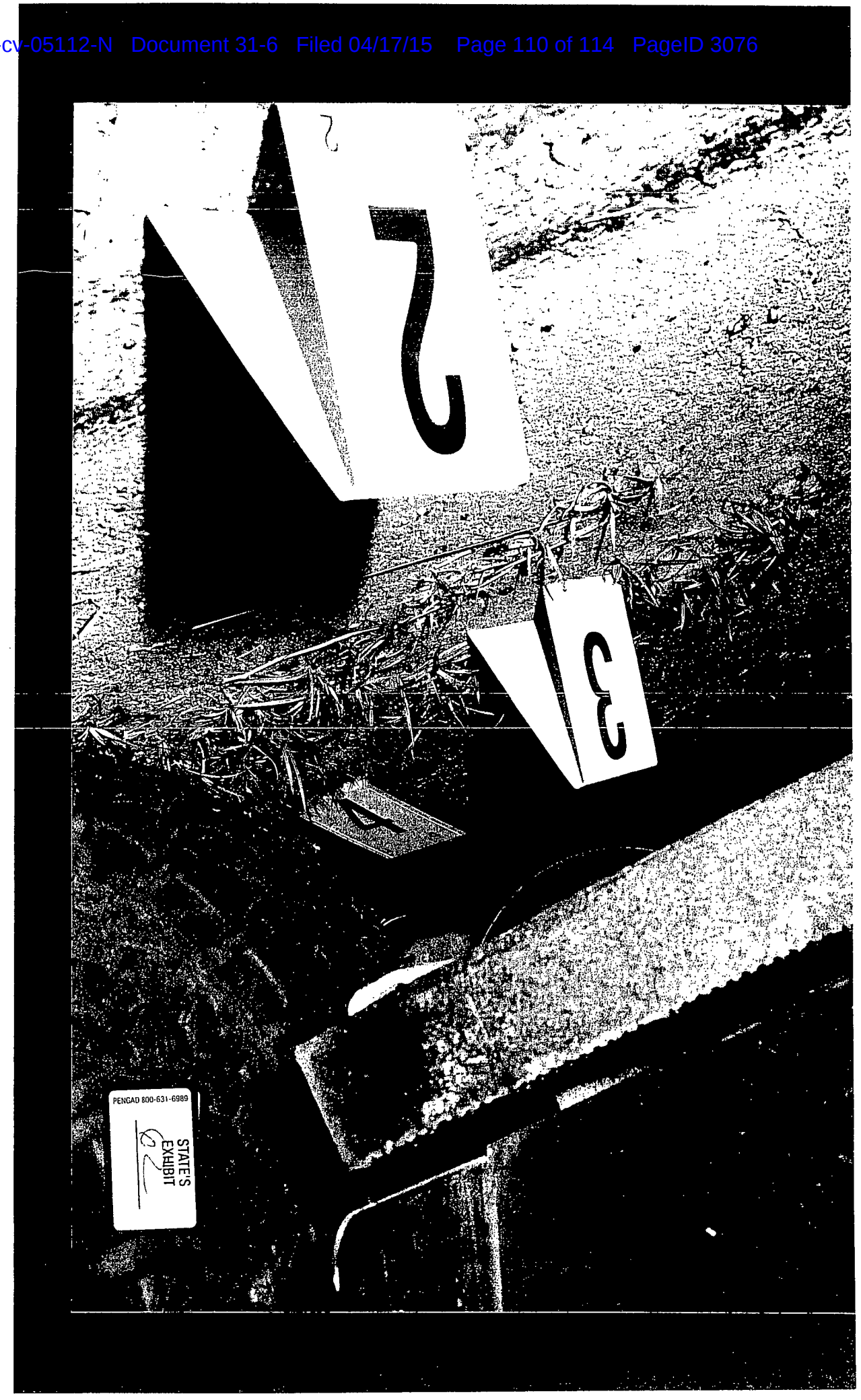
PENGAD 800-631-6989
STATE'S EXHIBIT

STATE'S EXHIBIT NO. 63

ASSAULT PISTOL

(NONREPRODUCIBLE)

STATE'S EXHIBIT NO. 64

CARTRIDGE CASING

(NONREPRODUCIBLE)

STATE'S EXHIBIT NO. 66

BULLETS

(NONREPRODUCIBLE)

THE STATE of TEXAS)

COUNTY of DALLAS)

I, BELINDA G. BARAKA, Official Court Reporter in and for the 194th Judicial District Court of Dallas County, State of Texas, do hereby certify that the exhibits included herein constitute true and complete duplicates of the original exhibits, excluding physical evidence, offered into evidence during the proceedings in the above-entitled and -numbered cause(s), as set out herein.

I further certify that the total cost for the preparation of this Reporter's Record is included in the original volume.

WITNESS MY OFFICIAL HAND this the 29th day of May, A.D., 2009.

BELINDA G. BARAKA, CSR #5028
Official Court Reporter
194th Judicial District Court
133 N. Industrial Blvd.
Dallas County, Texas 75207

Certification Expires: 12-31-09